# COVERAGE OF OUTPATIENT PRESCRIPTION DRUGS UNDER MEDICARE PART B

## HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

APRIL 23 AND JUNE 2, 1987

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# COVERAGE OF OUTPATIENT PRESCRIPTION DRUGS UNDER MEDICARE PART B

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THURSDAY, APRIL 23, 1987

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
*Washington, DC.*

The subcommittee met, pursuant to notice, at 9:40 a.m., in room B-318, Rayburn House Office Building, Hon. Fortney H. (Pete) Stark (chairman of the subcommittee) presiding.

[Press releases announcing the hearings follow:]

FOR IMMEDIATE RELEASE
THURSDAY, APRIL 16, 1987

PRESS RELEASE #10
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1114 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
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## THE HONORABLE FORTNEY H. (PETE) STARK (D. CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON COVERAGE OF OUTPATIENT PRESCRIPTION DRUGS UNDER MEDICARE PART B TO BE HELD ON THURSDAY, APRIL 23, 1987

The Honorable Fortney H. (Pete) Stark (D. Calif.), Chairman of the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives announced today that the Subcommittee will hold a hearing on coverage of outpatient prescription drugs under Medicare Part B. The hearing will be held on Thursday, April 23, 1987, beginning at 9:30 a.m., in room B-318 Rayburn House Office Building.

In announcing the hearing, Chairman Stark said, "Many low income elderly face a tough choice. They can spend their limited income on basic necessities, such as food or clothing, or on costly drugs needed to control painful symptoms and prevent further progression of disease. All other major industrial nations protect their elderly from these difficult choices by providing insurance coverage for prescription drugs.

"The issue is not an easy one. Coverage of drugs would increase costs at a time when we are struggling with the budget. Necessary measures to control costs could be controversial with manufacturers and retail druggists. Finally, a drug benefit could be expensive to administer."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

## Background

The failure to cover outpatient prescription drugs is a major gap in the current Medicare benefit package. Out-of-pocket expenditures for pharmaceutical drugs will average $161 per beneficiary this year or about 16% of total out-of-pocket expenses for acute care. Overall, the elderly spend more than $6 billion on prescription drugs each year.

A limited drug benefit could be developed that would cost between $1 to $2 billion a year. Such a benefit might include a deductible of between $200 to $500 per year with either 20% coinsurance or a $1 to $3 copayment per prescription. Coverage might be limited to drugs for chronic medical conditions.

To limit the costs of a prescription drug benefit, various cost control measures might be considered. These could be based upon the experience of the State Medicaid programs. Payment might be based on average wholesale prices plus a standard dispensing fee. A maximum allowable cost (MAC) policy might be used to encourage the use of generic drugs. Finally, a formulary might be used to exclude coverage of costly drugs when less expensive alternatives are available.

## WRITTEN STATEMENT IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, May 15, 1987, to Joseph K. Dowley, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

## SEE ENCLOSED FORMATTING REQUIREMENTS

* * * * *

FOR IMMEDIATE RELEASE
TUESDAY, MAY 26, 1987

PRESS RELEASE #16
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

## THE HONORABLE FORTNEY H. (PETE) STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON COVERAGE OF OUTPATIENT PRESCRIPTION DRUGS UNDER MEDICARE

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The Honorable Fortney H. (Pete) Stark (D., Calif.), Chairman of the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives announced today that the Subcommittee will hold a hearing on legislation to cover outpatient prescription drugs under Medicare. The hearing will be held on Tuesday, June 2, 1987, beginning at 10:00 a.m., in room B-318 Rayburn House Office Building.

In announcing the hearing, Chairman Stark said, "Many elderly have to take drugs for two or three chronic diseases, and spend hundreds of dollars each year on outpatient drugs. Prescription drugs are a catastrophic illness expense for many senior citizens and it makes sense for the Committee to broaden its catastrophic insurance bill to include coverage of prescription drugs. I expect to introduce legislation next week that will close this gap in catastrophic coverage for Medicare beneficiaries."

The purpose of the June 2 hearing is to provide an opportunity for comment on bills introduced by Mr. Stark and others.

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusionin the printed record of the hearing.

WRITTEN STATEMENT IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Monday, June 29, 1987, to Robert J. Leonard, Chief Counsel Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE ENCLOSED FORMATTING REQUIREMENTS

* * * * *

Chairman **Stark**. The Subcommittee on Health will begin with its hearing on the coverage of outpatient prescription drugs under Medicare. We are going to receive testimony on Medicare's lack of coverage of outpatient prescription drugs.

This year, it is estimated the elderly will spend over $6.5 billion on prescription drugs. That's about $161 a beneficiary, or 16 percent of their total out-of-pocket costs for acute care.

This burden can become more severe as the costs continue to increase. During the past 20 years, out-of-pocket spending by the elderly has increased four fold. Despite the slowing of general inflation, inflation in drug costs has continued, and it seems to outpace the Consumer Price Index by a magnitude of several times. From 1980 to 1985, it was almost double the general rate of inflation.

We estimate that more than 2.5 million of our over 31 million beneficiaries will spend over $500 this year, and that they may face a tough choice: they can spend their income on necessities—shelter, food—or on costly drugs generally needed to control pain and symptoms or to halt the progression of disease.

Every other major industrial nation protects their elderly from these difficult choices by providing insurance coverage for prescription drugs, and I am reminded that some nations nationalize their pharmaceutical industry.

Medicare's lack of coverage is shortsighted. Many medical experts agree that many disabling diseases, such as chronic renal failure, stroke, heart disease and so forth can be prevented by simple medications. The cost of the necessary medications is often much less than the cost involved in treating the advanced disease. However, because we don't cover the drug costs, many elderly fail to receive the proper treatment or have to return to a health care facility as an alternative to buying costly drugs.

First dollar coverage of outpatient prescription drugs would cost over $6 billion a year. Because of that, it appears impractical at this time to deal with first dollar costs; but if a more limited benefit could be developed, it might cost between $1 and $2 billion a year. At this point, the committee has no idea where that money might come from, but always enjoying the sweet anticipation of extra revenues, we thought we had better be prepared and have a place to spend the money; it would not be this committee's suggestion that another $1 or $2 billion from the Medicare program go to Star Wars or a nuclear aircraft carrier.

Such a benefit might be structured somewhere between $200 and $500, with a deductible between $200 and $500, and a $2, perhaps $3 copayment or a 20 percent coinsurance. The benefit might be limited to certain drugs commonly used for the treatment of chronic disease.

There are a variety of options we would like to discuss this morning. I think it is important for the Federal Government to pay for the prescription drugs that they purchase and use any form of cost containment. Bidding, formularies and all the other approaches to holding down cost would be controversial at best.

I think Medicare has shown us that if there is not some cost containment, the instincts of the providers is to charge whatever the traffic will bear. Meanwhile we watch costs escalate outrageously and exponentially.

So the real question before us this morning is can we develop a benefit? We all know what is needed. Can we develop one which we can afford, provide some real help, and will be accepted by all the parties involved—the suppliers and the intermediaries, the professionals who administer and prescribe the formulas—that poses a lot of difficult questions.

I guess I am disappointed that one of the principal participants in this symphony is absent. The Pharmaceutical Manufacturers Association is the predominant advocate for the pharmaceutical industry in this country. They declined to be here this morning, although informally they expressed certain concerns. I will attempt to pose questions to some of the other witnesses that might address some of the concerns of that group.

I would add that if we are to legislate this field, we will not wait. The absence of the PMA does not suggest for a moment that any legislation this committee may have to compound will wait for a subsequent hearing. One of the unfortunate problems of tight schedules is that we must move ahead when the time comes, and I doubt if this committee will report a bill. I rather suspect that we may hear this issue raised again in conference and if any of you were waiting for some great legislative tablet to be chiseled into stone and handed down from the podium, do not hold your breath.

I think that what we will anticipate is that this may come later in reconciliation, and we would like to be prepared to deal with it if the opportunity is presented to us.

Our first witness panel consists of Mr. Jack Guildroy, a member of the National Legislative Council of the American Association of Retired Persons. Mr. William Hutton, the executive director of the National Council of Senior Citizens.

I ask the witnesses to come forward to the witness table, please, and urge them not to read their prepared statements, but to summarize or expand on them in 5 or 10 minutes, and to allow members of the subcommittee to inquire of them. I think we will get a lot of dialog that will be of more help to the committee that way.

Without objection, your entire prepared statements will appear in the record.

Welcome to the committee, gentlemen.

Mr. Guildroy, would you like to proceed?

## STATEMENT OF JACK GUILDROY, MEMBER, NATIONAL LEGISLATIVE COUNCIL, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. GUILDROY. Thank you, Mr. Chairman.

On behalf of the 25 million members of the American Association of Retired Persons, thank you for this opportunity to state our views on Medicare prescription drug benefits. AARP commends you and your colleagues for your interest in developing such a benefit.

In the United States, persons aged 65 and older represent only 12 percent of the population, but they consume 30 percent of the prescription drugs. And, while three-fourths of all adults aged 19 to 64 have insurance coverage for outpatient prescriptions, only 41 percent of Americans over the age of 65 have such protection.

Prices for prescription drugs began to skyrocket in 1981. Between 1981 and 1985, prices for prescription drugs rose 56 percent, compared to 23 percent for general inflation. Last year, prescription drugs rose 8.6 percent, while general inflation increased by only 1.9 percent.

These high prices affect both the willingness of private insurers to cover drugs, and the behavior of older Americans. A 1986 AARP national survey showed that older consumers cite the cost of drugs as the second most important reason for not getting a prescription filled as ordered by their doctors. As recently as 1982, this reason was fourth.

Since drugs are——

Chairman STARK. Jack, what was the first reason?

Mr. GUILDROY. The first reason in the most recent survey was the belief of patients, after they left the physician's office, that the drugs really didn't help.

Chairman STARK. And that's generally. Are there any other reasons?

Mr. GUILDROY. Back in 1982 there was concern about the side effects of some of the drugs.

Chairman STARK. Scared of them. Thank you.

Mr. GUILDROY. Since drugs are among the most cost-effective of medical care components, this change may have the untoward result of increasing more costly physician visits or even hospitalizations.

Prescription drugs create burdens in most elderly families. Over three-fourths of the elderly use prescription drugs, and among those with limitations due to chronic health conditions, the proportion rises to 90 percent. Many of those with high drug expenses are not the same persons who would have high expenses from a hospital stay. Rather, older Americans with chronic conditions seem to be the heaviest users of prescription drugs.

Some persons would try to introduce drug benefits gradually and would limit the benefit to specific types of drugs. Meaningful distinctions between so-called life-saving and other essential drugs are difficult indeed to make.

A careful look at drug use suggests that we must be certain to protect the chronic user. A relatively healthy older person, suffering from four common but chronic conditions—arthritis, high blood pressure, angina and an ulcer—would pay over $1,000 per year in drug costs alone.

The heaviest users of these drugs are likely to be women, mostly widows, living alone, the most financially vulnerable of all the elderly.

Currently, eight States have implemented programs to cover outpatient drugs for elderly residents who meet eligibility requirements. And the ninth State, New York, will begin coverage in October.

AARP believes that congressional efforts to implement a drug benefit program for the elderly under Medicare would be enhanced by studying these successful state programs.

AARP recommends a Medicare prescription drug benefit that would provide meaningful coverage to beneficiaries who are faced with catastrophic prescription drug costs. This benefit would include:

A $500 deductible and a 20 percent coinsurance payment;

Continuation of Medicare's existing prescription drug benefits; and

Medicaid coverage of individuals up to 100 percent of the federal poverty level, in the same way that this coverage for deductibles, coinsurance and premiums is included in the Stark-Gradison catastrophic plan.

Further, we recommend that beneficiary coinsurance payments be counted toward a $1,000 catastrophic cap on Part B expenses.

Our recommendations for implementation and financing are as follows:

A fair pricing mechanism, which takes into account average wholesale prices, dispensing fees and other reasonable factors.

Administration of the benefit through participating pharmacies.

The benefit should be phased in over a period of several years.

This benefit would be financed through a premium and by bringing all state and local employees into Medicare, and by raising the tax on cigarettes.

The high deductible in this benefit is compatible with the principle of catastrophic coverage, but the low coinsurance would offer a beneficiary significant relief when the cap is reached. A recent CBO cost estimate which looked at the cost of a benefit with a $500 deductible and high administrative cost projected that such a benefit would cost $680 million next year. This estimate does not include the beneficiary coinsurance that we include in our benefit. Our estimates show that nearly 20 percent of Medicare beneficiaries would be helped by this benefit.

Implementation of the benefit we propose would yield information about utilization levels, cost and cost-containment, and administration. If actual experience in administering the benefit falls within reasonable projections, then we believe it would be appropriate to lower the deductible in years to come. Ideally, the deductible should be no higher than $200.

We hope that this year will be the year of meaningful catastrophic coverage for older Americans. We recognize that after this year we will still have far to go in protecting the Nation against some of the most burdensome health care costs. But in the area of prescription drugs, we can take steps this year to provide a benefit that is fiscally sound and administratively manageable. We urge the members of this committee not to pass up this opportunity.

Thank you, Mr. Chairman.

[The prepared statement follows:]

## STATEMENT OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS, PRESENTED BY JACK GUILDROY, MEMBER, AARP NATIONAL LEGISLATIVE COUNCIL

I am pleased to be here today to represent the American Association of Retired Persons. AARP is a membership organization of 25 million Americans age 50 and older. We are encouraged by your interest in prescription drugs and look forward to working with you to expand protection for older Americans in this vital area.

Before discussing some possible approaches to expanding Medicare to cover prescription drugs, my testimony will discuss some facts that help establish the nature of the problem. Specifically, we will discuss:

1. Drug costs and overall use;
2. Specific areas of need; and
3. Some recent state efforts to help with drug expenses.

### Prescription Drugs and Older Americans

AARP has always maintained a keen interest in pharmaceutical issues; older Americans consume a disproportionately high amount of prescription drugs and are less well protected in this area than younger members of the population. In the U.S. persons aged 65 and older represent only 12 percent of the population, but they consume 30 percent of the prescription drugs. And, while three-fourths of all adults aged 19 to 64 have insurance coverage for outpatient prescriptions, only 41 percent of Americans over the age of 65 have such protection. The high costs of drugs and the failure of the private sector to offer solutions underscore the need for legislation to protect older Americans.

The reluctance of private supplemental policies to cover drugs surely arises in part from the tremendous growth in the price of pharmaceuticals. Prices for prescription drugs began to skyrocket in 1981 and have far outpaced the overall Consumer Price Index. Between the years 1981 and 1985, prices for prescription drugs rose 56 percent, compared to 23 percent for general inflation. Last year, prescription drugs rose 8.6 percent, while general inflation increased by only 1.9 percent.

These high prices also affect the behavior of older Americans. An AARP national survey taken in 1986 showed that older consumers cite the cost of drugs as the second most important reason for not getting a prescription filled as ordered by their doctors. As recently as 1982, this reason was fourth. Clearly, cost has become an increasingly important factor in patient's non-compliance with recommended treatment. Since drugs are among the most cost-effective of medical care components, this increasing noncompliance with prescribed drug regimens may have the untoward result of increasing more costly physician visits or even hosptializations.

Perhaps as much as any type of medical care expense, prescription drugs create burdens in most elderly families. Over three-fourths of the elderly use prescription drugs, and among those with limitations due to chronic health conditions, the proportion rises to 90 percent. Interestingly, many of those with high drug expenses are not the same persons who would have high expenses from a hospital stay. Rather, older Americans with chronic conditions seem to be the heaviest users of prescription drugs.

## Acute and Chronic Conditions and Drug Use

Some who would try to introduce drug benefits gradually would limit the benefit to specific types of drugs. Problems arise here, however. When, for example, do we assume one type of drug is more essential than another? Meaningful distinctions between "life-saving" and other essential drugs are difficult indeed to make. A careful look at drug use suggests that we must be careful to protect the chronic user.

Although available data do not offer a clear cut look at the relationship between medical conditions and drug use, we can discern a number of areas where the elderly are likely to be particularly vulnerable to high drug costs. For example, according to AARP's mail order pharmacy, the ten most commonly dispensed drugs are all for the treatment of hypertension and/or heart conditions. More than a third of all elderly persons suffer from hypertensive disease; in fact this is the second most common chronic condition following arthritis. Moreover, costs of such treatment are not cheap. One common hypertensive drug at the AARP pharmacy (where prices are likely to represent an underestimate of costs to most consumers) is $24.45 for 100 tablets--about a one month supply.

Since many older Americans suffer from multiple chronic conditions, the costs of prescription drugs can multiply quickly. For example, a relatively healthy older person suffering from four common but chronic conditions--arthritis, high blood pressure, angina and an ulcer--would pay over $1000 per year in drug costs alone. (See attached Table 1).

As already mentioned, older Americans are very likely to suffer from arthritis or hypertension. In addition, more than a fourth of all the elderly suffer from heart conditions (see Table 2). Diabetes also ranks high among the elderly--affecting over 8 percent of those over age 65. All of these chronic conditions are likely to require considerable outlays for prescription drugs.

The heaviest users of these drugs are likely to be women living alone. Chronic conditions are problems of the very old, a group dominated by widows. And these women are the most financially vulnerable of all the elderly. For example, one fifth of such women live below the poverty line.

Thus, while we hear a lot about immuno-suppressant drugs and other extremely expensive pharmaceuticals, it is likely to be the more common ailments that lead to high drug expenses, and the burden will be greatest on those least able to pay. The most common prescriptions are for cardiovascular problems, pain relief, and central nervous system problems (see Table 3). These are not the glamorous drugs--merely the ones needed by the elderly to help sustain a reasonable life style. Moreover, three of the four chronic conditions in our example above are life-threatening if essential medications are not taken.

We should not discount the burden of drug costs on those who are acutely ill. Although few will be affected by the immuno-suppressant drug benefit in current law, the drugs are very expensive. The Congressional Budget Office estimates that the costs of providing immuno-suppressant drugs to 9000 Medicare beneficiaries with kidney transplants will approach $35 million in 1987 (or about $4000 per transplant beneficiary). Restricting any new drug benefit to the expansion of immuno-suppressants would constitute only a very minor improvement in Medicare coverage.

Some Medicare beneficiaries could avoid hospitalization or be discharged earlier if certain drug therapies were covered on an outpatient basis. For example, recent studies suggest that Medicare hospital expenditures could be reduced significantly through coverage of at-home antibiotic infusion for several categories of Medicare patients (i.e. those suffering from diseases such as osteomyelitis, endocarditis, and cellulitis which typically require a several-week course of intravenous antibiotics). This limited expansion of the Medicare benefit could be made now, even in the absence of additional funding.

## State Efforts

Currently eight states have implemented programs to cover outpatient drugs for elderly residents who meet eligibility requirements. New York, the ninth state, will begin coverage for its plan starting this October.

All programs have differing co-pays and eligiblity requirements, but basically all serve to cover marginally poor older persons whose incomes are too high to qualify for Medicaid. AARP believes that Congressional efforts to implement a drug benefit program for the elderly under Medicare would be enhanced by studying these successful state programs. We conclude that these programs demonstrate the feasibility of providing drug coverage under Medicare.

For example, the Pennsylvania system, PACE (Pharmaceutical Assistance Contract for the Elderly), was started in 1984 and now has 458,000 enrollees. PACE covers all drugs that are available by prescription only. In their first two and one-half years of operation, PACE provided $234 million in benefits and spent only $15.5 million (about 6 percent) on administrative costs. Two categories of drugs, cardiac and gastrointestinal, account for 60 percent of the PACE budget.

AARP Recommmendations

AARP recommends a Medicare prescription drug benefit that would provide meaningful coverage to beneficiaries who are faced with catastrophic prescription drug costs. This benefit would include:

o a $500 deductible and a 20 percent coinsurance payment

o continuation of Medicare's existing prescription drug benefits; and

o Medicaid coverage of individuals up to 100 percent of the federal poverty level, in the same way that this coverage for deductibles, coinsurance and premiums is included in the Stark-Gradison catastrophic plan.

o Further, we recommend that beneficiary coinsurance payments be counted toward a $1000 catastrophic cap on Part B expenses.

Little data exist on the potential utilization of a full Medicare prescription drug benefit, its cost, or its administration. AARP recognizes the seriousness of these considerations and, therefore, is proposing a benefit that is fiscally responsible, administratively manageable, a source of useful data, and, most importantly, a benefit of real value. Accordingly, our recommendations for implementation and financing are as follows:

o Pricing--A fair pricing mechanism, which takes into account average wholesale prices, dispensing fees and other reasonable factors is an essential component of this benefit.

o Administration--Administration of the benefit would employ the concept of participating pharmacies. Beneficiaries would enroll with a participating pharmacy or pharmacies each year. Pharmacies would batch claims by individual beneficiaries and submit them together when the deductible has been met.

o Timeline--The benefit should be phased in over a period of several years to allow for proper implementation mechanisms to be put into place.

o Financing--The benefit would be financed through a premium and by bringing all state and local employees into Medicare.

The high deductible in this benefit is compatible with the principle of catastrophic coverage, but the low coinsurance would offer a beneficiary significant relief when the cap is reached. A recent CBO cost estimate which looked at the cost of a benefit with a $500 deductible and high administrative cost projected that such a benefit would cost $680 million in 1988. This estimate does not include the beneficiary coinsurance that we include in our benefit. Our estimates show that nearly 20% of Medicare beneficiaries would be helped by this benefit. In addition:

o The approach we propose is more equitable than drug-specific approaches in that it covers both medication needed by patients with chronic conditions and the very high cost of medication needed for treatment of acute care conditions.

o Because the benefit covers the full range of prescription drugs, it can be used to develop data on utilization (diagnosis/types of drugs prescribed/price) by those who meet the deductible.

o The benefit would be easy for beneficiaries and physicians to understand, since coverage is not based on specific types of diseases of drugs prescribed.

Implementation of the benefit we propose would yield information about utilization levels, cost and cost-containment, and administration. If actual experience in administering the benefit falls within reasonable projections, then we believe it would be appropriate to lower the deductible in years to come. Ideally, the deductible should be no higher than $200.

## Conclusion

We hope that 1987 will be the year of meaningful catastrophic coverage for older Americans. We recognize that after this year we will still have far to go in protecting the nation against some of the most burdensome health care costs. But in the area of prescription drugs we can take steps this year to provide a benefit that is fiscally sound and administratively manageable. We urge the members of this committee not to pass up this opportunity.

## TABLE 1

### Rx DRUG COSTS EXAMPLE

Even if one is not catastrophically ill, one can incur rather catastrophic prescription bills. The example below is of a relatively healthy older person who suffers from four common, but chronic conditions: arthritis, high blood pressure, angina and an ulcer. All drugs listed are commonly prescribed but also newer drugs so that generic copies are not yet available.

| | | Price per 100 at AARP Pharmacy |
|---|---|---|
| Diagnosis: | Arthritis | |
| Treatment: | Feldene (piroxicam) 20 mg. q.d.* | $102.45 |
| Diagnosis: | Hypertension (high blood pressure) | |
| Treatment: | Dyazide (triamterene & HCT) 1 cap. q.d. | $ 19.65 |
| | Tenormin (atenolol) 50 mg. q.d. | $ 39.15 |
| Diagnosis: | Angina (heart pain) | |
| Treatment: | Procardia (nifedipine) 10 mg. t.i.d. | $ 24.45 |
| Diagnosis: | Ulcer | |
| Treatment: | Tagamet (cimetidine) 300 mg. (q.i.d for 6-8 weeks, then 300 mg. q.d.) | $ 39.95 |

Occasional use of over-the-counter preparations:
- Metamucil
- Milk of Magnesia

| | |
|---|---|
| Daily prescription drug costs: | $ 3.93 (for 2 months, then $2.73/day) |
| Monthly prescription drug costs: | $117.90 (for 2 months, then $81.90/month) |
| Yearly prescription drug costs: | $1,054.80 |

Note: Dosages listed are conservative. Prices are also on the conservative side since the AARP Pharmacy is both not-for-profit and buys in large quantities. Prices are accurate as of October 1986.

*q.d. - once a day
t.i.d. - three times a day
q.i.d. - four times a day

## TABLE 2

## PREVALENCE OF TOP CHRONIC CONDITIONS AMONG OLDER AMERICANS

| Condition | Total persons 65 years and older | Rate per 1000 persons for those 65 years & older |
|---|---|---|
| Arthritis | 11,547,889 | 464.7 |
| Hypertensive disease | 9,406,958 | 378.6 |
| Hearing impairments | 7,051,238 | 283.8 |
| Heart Conditions | 6,883,416 | 277.0 |
| Chronic sinusitis | 4,562,037 | 183.6 |
| Visual impairments | 3,395,397 | 136.6 |
| Orthopedic impairments | 3,185,565 | 128.2 |
| Arteriosclerosis | 2,410,125 | 97.0 |
| Diabetes | 2,073,037 | 83.4 |
| Varicose veins | 2,067,311 | 83.2 |
| Hemorrhoids | 1,637,487 | 65.9 |
| Frequent constipation | 1,471,915 | 59.2 |
| Disease of urinary system | 1,395,187 | 56.1 |
| Hay fever | 1,290,449 | 51.9 |
| Corns and callosities | 1,289,933 | 51.9 |
| Hernia of abdominal cavity | 1,220,156 | 49.1 |

Source: "DataWatch", Health Affairs, Spring 1985.

## TABLE 3

## PERCENT DISTRIBUTION OF PRESCRIPTIONS BY THERAPEUTIC FUNCTION FOR AGED NON-INSTITUTIONALIZED MEDICARE BENEFICIARIES

## (1980)

| | | |
|---|---|---|
| 1. | Cardiovascular/Renal | 39.4% |
| 2. | Pain Relief | 11.3 |
| 3. | Affecting Nervous System | 8.3 |
| 4. | Hormonal Agents/Hormones | 7.3 |
| 5. | Respiratory/Allergy | 7.0 |
| 6. | Gastrointestinal | 5.6 |
| 7. | Homeostatic/Nutrient | 5.0 |
| 8. | Antimicrobial | 4.9 |
| 9. | Ophthalmological | 3.1 |
| 10. | Others | 8.1 |

Source: LaVange, Lisa (Research Triangle Institute) and Herbert Silverman (HCFA), "Prescription Drug Utilization and Expenditure Patterns of Aged Medicare Beneficiaries", Draft Report NMCUES Series (in press), September, 1984.

Chairman STARK. Thank you.

Mr. Hutton?

## STATEMENT OF WILLIAM R. HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS, ACCOMPANIED BY ERIC SHULMAN

Mr. HUTTON. Thank you very much, Mr. Chairman, for holding this hearing to take a closer look at one of the most important issues in the catastrophic debate: coverage of prescription drugs. Thank you also for giving us the opportunity to testify this morning.

Our testimony is divided into four parts: The need for such coverage; the cost of drugs; methods of financing the benefit; and options for implementing the proposal. I will summarize our testimony in each of these areas.

The need for coverage. For 75 percent of the elderly population, prescription drugs represent the largest out-of-pocket health care expense they will face. Many elderly individuals take 4 or 5 drugs a day and all elderly on average fill at least 12 prescriptions every year. In fact, while people over age 65 represent only 12 percent of the population, they take 30 percent of all prescription drugs used in this country. It's also important to realize that the over-65 population is prescribed drugs 3 times more often than the under-65 population.

The elderly in one year take, on average, 10.5 prescription drugs compared to 4.2 prescriptions for the rest of the population. Many seniors with chronic diseases such as arthritis, diabetes, cancer and cardiovascular disease must take prescription drugs every day of their lives.

Drug costs. NCSC believes that the staggering price increases of prescription drugs have been wholly unjustified. They are certainly not justified on the basis of the amount of money the pharmaceutical people spend on research and development.

Since July 1985, while the CPI rose 2.7 percent, retail prescription prices have risen 12.2 percent, or four and a half times faster.

For the estimated 6.2 million near-poor senior citizens, whose incomes are below 200 percent of poverty, this inflation rate has become an intolerable burden. These people can only be helped by an expansion of Medicare to cover prescription drugs in some way. They are not eligible for Medicaid.

Financing the benefit. As we have said in previous testimony, Mr. Chairman, we believe that the best, fairest, even most logical way to pay for a prescription drug benefit is to require State and local employees to pay the hospital insurance payroll tax. It is simply unfair to continue to allow one group of workers to receive privileged treatment in terms of paying for and receiving the benefits of Medicare protection.

Let's not forget that out-of-pocket costs for the elderly have risen sharply, between 1980 and 1985, as a direct result of high health care inflation and Medicare beneficiary cuts. We believe it's time to give some of that back.

However, if the subcommittee chooses not to use State and local coverage as a financing mechanism, we urge that alternative financing be found. Although we would be extremely reluctant to increase the part B premium any further, I believe our members would be willing to pay for a prescription drug benefit if it would help relieve this terrible burden.

I got a letter last week from one of our members, Victor Mance of Madison, IL. He says:

> * * * sure do hope that you will be able to convince our government to add prescription drugs on Medicare; more so than nursing homes, as everyone likes to stay at home. We wouldn't even mind paying something extra for the prescription addition to Medicare, as drugs are really getting so high in cost * * *"

Coverage options. Ideally, a deductible should be set at a point where it would be low enough to enable needy seniors to benefit from the provision, but high enough to help keep the overall program costs down. Of course, as the deductible moves higher, fewer people are helped; and those who are helped are helped for shorter amounts of time.

As has been pointed out in this regard, a high deductible might be reached only in the last month of the year, meaning that coverage would kick in only 1 month out of 12—hardly worth the administrative effort.

It might be worthwhile for the subcommittee to consider imposing no deductible, and using a copay to finance the cost of the drugs, with some upper limit set on out-of-pocket co-pays for very expensive drugs. This would resolve a major administrative problem, while still keeping the overall cost of the program down.

At the same time, NCSC would hope that any copay would be set at a point low enough so as not to be prohibitive for lower income seniors. A copay could be structured either in the way of a straight dollar amount per prescription filled or as a percentage of the cost of the prescription. However, we would point out that a percentage copay avoids the problem of paying the same amount for a prescription whether it is for 100 pills or 10.

Other cost controls. One of the most important concepts to keep in mind in discussing a prescription drug benefit is the inherent ability it gives the Federal Government to control escalating drug costs. Just as PPS helped reduce the problem of double-digit inflation in hospital care, so too could inclusion of drugs under medicare help solve the problem of inflation in that part of the health care industry. The Federal Government, as a major purchaser of prescription drugs, would have the ability to institute cost-control mechanisms that would likely be followed by private payors.

Some suggestions for cost controls: A formulary would significantly help to control the cost of a prescription drug benefit. A formulary is simply a list of approved drugs for which reimbursement can be made under the program. This list, which can be compiled through an Institute of Medicine Consensus Conference or some other group of medical experts, would include drugs that were found safe, effective, and medically necessary in the treatment of various conditions.

Utilization review is an important element of keeping costs low and quality high.

Competitive bidding could be used as a very important and potent form of cost control. Already used by the Department of Defense and the Veterans' Administration in their prescription drug benefits, these two agencies invite bidding from qualified drug manufacturers.

Mr. Chairman, this issue is not a new one. The specific coverage and administrative issues we are grappling with have been dealt with many times in the past.

The timing and possibility for action are the only new parts of this debate. It is entirely possible and entirely warranted to include coverage of prescription drugs in the catastrophic package before us. We stand on the verge of doing the right thing, but seem a bit reluctant to take the plunge.

On behalf of the 4.5 million members of the National Council of Senior Citizens, I urge you to enact such a proposal this year—going slowly as necessary, phasing in the proposal, and collecting additional data as we go along in a careful and measured way.

[The prepared statement follows:]

## Statement of William R. Hutton, Executive Director, National Council of Senior Citizens

Mr. Chairman:

Thank you very much for holding this hearing to take a closer look at one of the most important issues in the catastrophic debate: coverage of prescription drugs. Thank you also for giving us the opportunity to testify this morning. The National Council of Senior Citizens has worked tirelessly for many years on this specific issue and we are very grateful for the sincere interest in prescription drug coverage that you and the Members of your Subcommittee have shown.

Without a doubt, the list of changes, improvements, and additions that should and could be made to our Federal health programs is nearly limitless. But our ability to make these changes is severely limited by our ability to finance them. So we are forced to choose only a few from a long list of meritorious ideas. When we talk to our members and ask them what the most important changes or improvements are that could be made--when we ask them what they really want--I suspect the answers we get are very similar to what your constituents tell you. Almost without fail, the most important items to seniors themselves are long-term care and prescription drug coverage under Medicare.

Some of our members place a higher priority on long-term care, others on prescription drugs. As an example, I offer you the words of an NCSC member who wrote us just last week:

> "...sure do hope that you will be able to convince our government to add prescription drugs on Medicare; more so than nursing homes, as everyone likes to stay at home. We wouldn't even mind paying something extra for the prescription addition to Medicare, as drugs are really getting so high in cost...."
>
> Victor Mance
> Madison, Illinois

### I. NEED

For 75 percent of the elderly population, prescription drugs represent the largest out-of-pocket expense they will face. Many elderly individuals take four to five drugs a day and, on average, fill at least 12 prescriptions every year. In fact, while people over age 65 represent only 12 percent of the population, they take 30 percent of all prescription drugs used in this country. It's also important to realize that the over-65 population is prescribed drugs three times more often than the under-65 population. The elderly in one year take, on average, 10.5 prescription drugs compared to 4.2 prescriptions for the rest of the population. Many seniors with the chronic and debilitating diseases of arthritis, diabetes, cancer, and cardiovascular disease must take prescription drugs every day of their lives for a period of many years.

### II. COST

The costs seniors face for prescription drugs are enormous. The elderly's drug bill amounts to over $9 billion annually--more than twice that of the rest of the population. Payments for drugs represent 20 percent of the elderly's total out-of-pocket health care costs.

Unfortunately, unlike most other health care costs, there are extremely few sources of coverage for the costs of prescription drugs. Neither Medigap nor Medicare will pay for the cost of these drugs outside of a hospital. In fact, a recent statement released by Aetna on this subject said, "Medicare doesn't cover many items, such as drugs....Neither do most Medicare supplement policies, which are generally based on what Medicare does cover." Even Medicaid only covers the costs of prescription drugs for one-third of the poor, leaving without protection 6.2 million near-poor seniors whose incomes are less than twice the Federal poverty line. This means that 80 percent of the elderly have to pay these costs out of their own pockets--amounting to over $7 billion annually.

For many seniors, prescription drug costs are catastrophic in the truest sense. As witnesses for the Department of Health and Human Services told this Subcommittee in a hearing held last month, more than two-thirds of the elderly population has out-of-pocket expenses due to prescription drugs each year. 6.3 percent of the elderly accounted for 55 percent of total out-of-pocket expenditures, and one percent of the elderly accounted for 15 percent of total out-of-pocket expenditures. Clearly, the burden falls very heavily on a few, and for most seniors, no coverage alternatives exist.

The costs of prescription drugs can be prohibitive for these seniors. According to one Public Health Report, 15.5 percent of elderly patients with prescriptions said they were unable to pay for the drugs. Many of these patients find themselves "too wealthy" to be on Medicaid, but too poor to be able to meet these costs themselves. For many of these seniors, being handed a prescription amounts to being handed a choice: pay the rent, buy groceries, or fill the prescription. Not surprisingly, seniors in this situation often choose to do without the drugs they need for no reason other than they can't afford them--a truly disgraceful situation and one that should not exist in our health care system.

Neither is the situation a good one even from the straight dollars and cents point of view. Outlays for drug costs can be more than offset by savings. After the State of New Jersey implemented its Pharmaceutical Assistance to the Aged (PAA) program, Medicare recipients had, on average, $238.50 less in inpatient hospital reimbursement costs than a comparable group had in Pennsylvania where no program was offered. (Unpublished study, Department of Pharmacy Practice, University of South Carolina.)

Juxtapose high costs with the extraordinarily high rate of inflation and high rates of profit in the prescription drug industry and it's easy to see a big part of the reason for the increased financial burden borne by the elderly. Since July 1985, while the CPI has risen 2.7 percent, retail prescription drug prices have risen 12.2 percent--a record four and one-half times greater. Last year, prices for prescription drugs outpaced all other medical costs. Tranquilizers and sedatives, which are often prescribed for older people, posted the biggest price increase of 13.2 percent. Between 1981 and 1985, while the CPI rose 23 percent, drug prices rose 56 percent. Costs of medications vital to the elderly in treating heart problems, high blood pressure, and arthritis have risen twice the rate of annual inflation since 1980.

At the same time, pharmaceutical corporations enjoyed profits of 13.2 cents on the dollar, compared to 4.6 cents for all manufacturers, and profits in this industry have traditionally outpaced the average profit for all other industries by two and even three times.

## III. FINANCING

The ability to finance and put in place a long-term care benefit may be beyond the current debate, but the ability to finance and put in place a prescription drug benefit under Medicare is clearly within our reach. In my opinion, the addition of a modest prescription drug benefit to the catastrophic package we have before us would greatly enhance the usefulness and attractiveness of the whole package.

As we have said in previous testimony before this Subcommittee, we believe that the best, fairest and most logical way to pay for prescription drug benefit is to require state and local employees to pay the HI (Hospital Insurance) payroll tax. This would raise about what is necessary to finance a drug benefit with a $300 deductible and a $2.3 co-pay. It is simply unfair to continue to allow one group of workers to receive privileged treatment in terms of paying for and receiving the benefits of Medicare protection.

To those who would say this should be done but for the purpose of deficit reduction, I think they are being greedy. Let's not forget that out-of-pocket costs for the elderly have risen 34 percent, between 1980 and 1985, as a direct result of high health care inflation and Medicare beneficiary cuts. We believe it's time to give some of that back.

However, if the Subcommittee chooses not to use state and local coverage as a financing mechanism, we would urge that alternative financing be found. Although we would be extremely reluctant to increase the Part B premium any further, as you have heard, our members would be willing to pay for a prescription drug benefit if it would help relieve this terrible burden.

## IV. COVERAGE OPTIONS

The National Council of Senior Citizens strongly urges this Subcommittee to include a prescription drug benefit in the catastrophic health care package. This coverage is badly needed and is not available from almost any other source. At the same time, it would give the catastrophic package broad appeal and give this nation's seniors a real source of protection from the high cost of drugs.

We suggest that a Medicare drug benefit should be phased in, should include some combination of deductibles and co-payments, and should include cost controls.

### Deductible

Ideally, a deductible should be set at a point where it would be low enough to enable needy seniors to benefit from the provision, but high enough to help keep costs down. Of course, as the deductible moves higher, fewer people are helped and those who are helped are helped for shorter amounts of time. As has been pointed out in this regard, a high deductible might be reached only in the last month of a year, meaning that coverage would kick in only one month out of 12--hardly worth the administrative effort. It might be worthwhile for the Subcommittee to consider imposing no deductible, and using a co-pay to finance the cost of the drugs, with some upper limit set on out-of-pocket co-pays for very expensive drugs. This would resolve a major administrative problem, while still keeping the overall cost of the program down.

### Co-pay

At the same time, NCSC would hope that any co-pay would be set at a point low enough so as not to be prohibitive for lower income seniors. A co-pay could be structured either in the way of a straight dollar amount per prescription filled or as a percentage of the cost of the prescription. However, we would point out that a percentage co-pay avoids the problem of paying the same amount for a prescription whether it is for 100 pills or ten.

### Other Cost Controls

One of the most important concepts to keep in mind in discussing a prescription drug benefit is the inherent ability it gives the Federal government to control escalating drug costs. Just as PPS helped reduce the problem of double-digit inflation in hospital care, so too could inclusion of drugs under Medicare help solve the problem of inflation in that part of the health care industry. The Federal government, as a major purchaser of prescription drugs, would have the ability to institute cost-control mechanisms that would likely be followed by private payors. The ability to control these costs is a tangential, but important, advantage of including drugs in a catastrophic package.

Some suggestions for cost controls follow.

1) A formulary would significantly help to control the cost of a prescription drug benefit. A formulary is simply a list of approved drugs for which reimbursement can be made under the

program. This list, which can be compiled through an Institute of Medicine Consensus Conference or some other group of medical experts, would include drugs that were found safe, effective, and medically necessary in the treatment of various conditions. An exception process could be easily added for cases where a physician feels it necessary to prescribe an alternative drug to one that is on the list due to a patient's particular circumstance. Many of the nation's top hospitals already use formularies with ease and high levels of physician acceptance.

2) A maximum allowable cost (MAC) program, especially when coupled with a formulary, can significantly control costs. Many states, most notably New York, which has the largest prescription drug coverage program in the nation, successfully use a MAC system to control costs.

3) A MAC system can be put in place that would allow pharmacies to charge patients over the MAC limit and rely on competition to keep costs low. If pharmacies are excused from assignment under this option, we would urge that they be required to post lists of prices they charge for commonly required drugs within plain view of purchasers to encourage people to shop around. After all, it is easier and more likely that senior citizens will change drug stores on the basis of price than that they will change doctors.

4) Utilization review is an important element of keeping costs low and quality high. This will hopefully avoid the serious problem of over and duplicative prescribing. Perhaps Medicare peer review organizations could play a role in this area.

5) As another option, each senior could be required to select a pharmacy at the beginning of the year. Selected pharmacies would handle all prescriptions for that senior and notify HCFA when the deductible level has been reached. North Carolina successfully uses this type of approach. One clear advantage to this approach is that a single pharmacist is aware of all the drugs being prescribed by several doctors for one patient. This would greatly reduce the problem of duplicative prescribing, as well as mixing inappropriate drugs.

6) Competitive bidding could be used as a very important and potent form of cost control. Already used by the Department of Defense and the Veterans Administration in their prescription drug benefits, these two agencies invite bidding from qualified drug manufacturers. The price breaks available to these two major purchasers through competitive bidding are startling. In fact, when prednisone's wholesale price was $18.50 per hundred, the DOD was buying it for $0.73 for the same amount and from the same company.

7) Alternatively, a prescription drug benefit could be developed to address only the costs of drugs used in the treatment of chronic illnesses suffered most by the elderly, like arthritis, diabetes, cardiovascular disease, and cancer.

## V. CONCLUSION

Mr. Chairman, this issue is not a new one. The specific coverage and administrative issues we're grappling with have been dealt with many times in the past. Not only do we have a body of knowledge to draw on from the states, we also have approximately 136 bills that have been proposed over the past 20 years to cover prescription drugs. Many of these proposals include formulary provisions, many include specific methods of cost containment, many include various arrangements of co-payments, deductibles, and financing. And still no action has been taken.

As a result, older people in 41 states still have no protection from these onerous costs. I would urge this Subcommittee to consider that reasonable solutions to many of these problems have been developed and proposed. The problems and solutions are not new.

The timing and possibility for action is the only new part of this debate. It is entirely possible and entirely warranted to include coverage of prescription drugs in the catastrophic package before us. We stand on the verge of doing the right thing, but seem a bit reluctant to take the plunge. On behalf of the 4.5 million members of the National Council of Senior Citizens, I urge you to enact such a proposal this year--going slowly as necessary, phasing in the proposal, and collecting additional data as we go along in a careful and measured way.

But, an opportunity for action missed on this issue this year will mean that we've missed the opportunity once again for true catastrophic reform of the sort for which seniors themselves are asking.

Chairman **Stark**. Thank you very much. Thank you both.

Jack, which State has the best program?

Mr. **Guildroy**. Well, I suspect that the State that has the best program, is New York. I am from New York State, and it is a very complicated program; it has several gradations, and those of us in New York State are really looking forward to it. We had extensive discussions with the legislature on the population's problems.

I don't know about every State program I am quite impressed with what I have heard about the situation in Pennsylvania, about the number of persons who have been helped. I think it has been in operation for a number of years; over half a million persons are involved.

The administration costs are, in our opinion, quite low; about 6 percent, I recall, and that one might be studied by Congress, if you are not familiar with it.

Chairman **Stark**. I guess I would like to ask both of you this: The questions that have been suggested all, I can kind of couple in that if we can only afford a billion or two—and obviously you are both thinking in terms of less than a billion, at least initially—I will come to that later.

But let's say we are talking in the billion dollar range, give or take, and we have got some money in. One alternative would be to spread this benefit across the spectrum of our 30-odd million beneficiaries.

The other approach would be to make it more comprehensive for perhaps the 25 percent of those beneficiaries who are below the poverty line or one and a half times the poverty line. Is that a better way to go?

That is an alternative, and it has been suggested: Why do we not just expand the Medicaid coverage? Start there and expand to the higher income people later, or do we start with the lower benefit and spread it across?

Obviously you are getting into the issue of needs testing which raises some questions. Do you have any preference, Bill?

Mr. **Hutton**. My major preference is, of course, to help the poorest. However, the Medicare program is not means-tested.

Mr. **Shulman**. Mr. Chairman, let me just add that I think one of the problems that you have to consider in this area is the question of administering some sort of a needs test; and in our opinion, when you consider the body of elderly people who basically need a drug benefit who would be helped by it, you are talking about a very large percentage of the elderly, since a large percentage of the elderly hover around the fringes of poverty, maybe a little bit above it, maybe a little bit below it.

So I do think you have to weigh consideration of how expensive it would be to administer a means test against how many people in fact would be helped and what the savings would be.

Chairman **Stark**. Well, it is pretty simple. Let's say we are talking about $1 billion . If my math is right, that is $30 a year a head. That pays their AARP membership, or their membership to Roosevelt, heaven forbid.

It is pretty straight math and simple to administer. If we have $1 billion, do we just hold their part B premium down by $30 a year? That is $30 a year in everybody's pocket—the people that you represent. The alternative is you start bunching those $30—everybody contributes that $30, if you will, to help a smaller group of the 30 million.

At the very base, that is what we are doing. I mean, we get into this question of how they spend it and how to control it, but that is the decision that faces us. There are a lot of other things that we are not touching on. This is kind of a question of what marginal benefits are needed and desired if there is some extra money. Maybe you would rather have us reduce the deficit by that figure.

Mr. GUILDROY. Mr. Chairman, I think you are aware of our position. I would like to emphasize the need for Medicare is a very serious idea.

Chairman STARK. That is not the issue. I happen to agree with this—but I guess that is the only thing your board ever agrees with me on—Medicare is indeed an entitlement.

Medicaid is not. A quarter of the people on Medicaid cannot join your association. Maybe they do not have enough money, but would you rather give the $1 billion to Medicaid and pay a larger percentage of that, or to Medicare where everybody gets it?

Let me phrase it differently.

Mr. GUILDROY. We do believe that Medicaid should buy into this program, be part of this program. We also have——

Chairman STARK. Let me ask the question a different way; I do not think I am getting through to you.

The catastrophe is certifiably larger. Let's take your example; you're the person spending $1,000. That is a much bigger catastrophe for the person on Medicaid than the person who does not qualify for Medicaid. Do you agree with me there?

Mr. GUILDROY. Yes.

Chairman STARK. The question is, should we pick up a bigger portion of the Medicaid person's catastrophe by putting it all in Medicaid, or should we spread it to everybody? Do you want to focus the first step in this program entirely toward the poorest of the elderly, or spread it evenly across the board? That is not opening up the weighted means test, that is simply asking if we should put it into a Medicaid program which exists, or spread it across to a Medicare program.

That is a dilemma. I am not suggesting that is an easy choice, but it is something that we have considered, and I am asking you, in all fairness, which do you think is better? That is a judgment. I do not know. Your opinion is——

Mr. GUILDROY. I think that I would rather see——

Chairman STARK. You would rather it go into the Medicare program.

Mr. GUILDROY. I think so.

Chairman STARK. And Bill?

Mr. HUTTON. I would rather it go where it would do the most good.

Chairman STARK. Well, that is——

Mr. SHULMAN. Mr. Chairman, I would add that for people on Medicaid, if they are eligible for Medicaid, then they do not have the problem of catastrophic cost, because the Medicaid program picks it up. In addition, Medicaid covers prescription drugs for eligibles, and we are likely, I think, to move to a level——

Chairman STARK. Medicaid qualification is pretty long, and in some states, it is nonexistent. So what I would suggest as a way to make this distinction would be to buy in more people.

Mr. SHULMAN. Which I think would cost in the neighborhood of $150 million; and as I understand it, there is money provided in the excess of the Stark-Gradison bill——

Chairman STARK. That only takes us to 100 percent.

Mr. SHULMAN. We are talking about a buy-in to 150——

Chairman STARK. Whatever it comes out to be, it is pretty linear, I think—120, 130, whatever we can. It is not very much until you get up much higher than that.

Mr. Coyne?

Mr. COYNE. Thank you, Mr. Chairman.

Mr. Guildroy, I imagine the program that you are referring to is what is known as the PACE program. Do you have any more information about the operation of that program?

Mr. GUILDROY. I do not have that information.

Mr. COYNE. It would be easy enough for us to get it; I just wondered if you had access.

Mr. Hutton, you indicated in your testimony that one source of revenue may be State taxation. I was wondering if you are aware that by doing so, there are declining revenues in the outyears; and by the year 2005, there is no revenue for payments. And I wonder what you would do then to raise revenue?

Mr. SHULMAN. In short, Mr. Coyne, we recognize that the revenues from State and local do not represent a permanent financing mechanism, but we also feel that there will be significant offsetting savings to the elderly from a Medicare prescription drug benefit in terms of cost control, that could then put them in a position to be able to afford to pay some additional amount for a program.

Mr. COYNE. Thank you, Mr. Chairman.

Chairman STARK. I am going to ask Jack some questions.

I think you suggested here this morning that you feel there should be a cost containment mechanism.

Mr. GUILDROY. Yes.

Chairman STARK. Do you support a kind of price review board or a national board that would set prices and a formulary and a very specific sort of listing, or do you have other cost containment proposals?

Mr. GUILDROY. I do not know that that meets the needs of the situation we have been concentrating on.

We are very leery of the idea of price controls, in lieu of what has happened to us. The Federal Government should be involved to some extent.

Chairman STARK. Your association also testified that the drug benefit should be phased in. Is that the old camel's head in the tent theory? Would it be reasonable to assume that AARP would like to get the benefit on the books and then worry about trying to increase it later? It makes good sense to me, but I just wondered if——

Mr. GUILDROY. Increase it how?

Chairman STARK. Increase it by lowering the deductible, or whatever.

Mr. GUILDROY. Oh, yes. As I said in my oral testimony, my feeling is it would be nice if——

Chairman STARK. But as a long range goal, that would be what you would——

Mr. GUILDROY. Eventually——

Chairman STARK. I understand that.

Mr. GUILDROY. I mean, we don't live in a long-range world.

But the phasing in. [Laughter.]

Chairman STARK. We would be out of business if you did.

Mr. GUILDROY. By phasing in we need a gradual approach.

Chairman STARK. One final question to both of you—and this is not as loaded as it sounds; I am going to ask the experts later—in the AARP testimony, we were presented a drug cost example, and without troubling you to list all of these things—because I cannot pronounce most of them—it deals with arthritis and hypertension and angina and ulcer.

The cost example indicates that prescription drug costs for those diseases comes to a little over $1,000 a year.

A person picking from various dishes in a pharmacy menu could get a morning pill that was substantially less expensive than another; a person can get treatment for the same thing by using generics or less expensive brands.

Would either of you be concerned if whatever format we came up with had some panel of experts which would not let you have the most expensive list that you presented, but some other list that a reasonable group of pharmacists would say would take care of the same thing? Is that a concern that either of you would have?

This scares the industry to death. You have presented here the industry's wish list; the highest cost stuff available, protected more by brand and patent than by reasonable selection. So that is what they would like to have.

Now I am not concerned, because I do not understand it. I would have to take somebody's advice if I were buying those pills; I would not know what the devil was in them; and I suspect your members do not either, but that is what I am getting at, are you all comfortable letting some kind of panel of experts help us contain costs?

Mr. HUTTON. If it is a panel of experts, they will not recommend anything which is bad for people. A real panel of experts will make good choices and so end up with a good relationship with people.

Chairman STARK. I might note that in the paper the AARP submitted, the prices are in their pharmacy, which is probably as good a deal as the average citizen can find; so I was not suggesting you were gaming it, but I was suggesting that there could be alternatives. It does not bother you, either, if it is what medically qualified persons would recommend.

Mr. GUILDROY. Congressman, it sounds very reasonable.

Mr. SHULMAN. Mr. Chairman, I just wanted to make one last point. I noted in your opening remarks the sense that you felt that if this issue were to come to pass, it would come to pass in reconciliation rather than in a catastrophic bill; at least that was the impression I got.

That concerns us a great deal because frankly, I think the reconciliation conference is going to be dominated more and more by efforts to reduce spending, and for us to try and get a prescription drug benefit in there, I see it being, to say the least, problematic; and yet I do see and think that it is valid to suggest that there are catastrophic costs associated with prescription drugs, and I do hope that you will reconsider that——

Chairman STARK. Well, your suggestion is well taken. I might add that the seniors groups and the unions are already fighting our plan for financing, and have not endorsed the meager bill we have; you might not even get that much. It is very difficult to be all good in this world.

The Chair would welcome, as would the full committee, any financing plans that we thought we could pass; albeit the one we had passed 6 to 5, as you gentlemen are aware. Anything less than that is a dead duck.

If Santa Clause arrives with another billion dollars, I would be happy to spend it. We hope the catastrophic bill will be out and gone long before reconciliation. There may be some change, even some small dollars available in reconciliation.

If the loose change is directly Medicare related, we would be inclined to spend it. There are alternatives. After we get done giving the doctors a 10 or 20 or 30 percent increase in their fees—which they so justly deserve—we might still have some money left. [Laughter.]

Then there are all kinds of alternatives when you come to reconciliation. I would prefer to do all of this outside of reconciliation because I think it is a very cumbersome process with which we have to legislate; but I do not see any other money.

I do see a possibility that we will be trading off in reconciliation. I would rather not trade off the whole catastrophic bill that way, because I am not competing with the elderly but with the Defense Department.

Thank you, gentlemen, very much.

Our next panel consists of Mr. Patrick Killeen, the assistant director, social security department of the United Auto Workers and Mr. Thomas Needham, the pharmaceutical consultant for the Blue Cross-Blue Shield Plan of Michigan.

Gentlemen, welcome to the committee. As with previous witnesses, your prepared testimony will appear in the record in its entirety, and we will welcome any additions to that testimony, or any summarizing you care to make.

Mr. Killeen, you are first; any way you want to proceed.

## STATEMENT OF PATRICK F. KILLEEN, ASSISTANT DIRECTOR, SOCIAL SECURITY DEPARTMENT, ACCOMPANIED BY ALAN REUTHER, ASSOCIATE GENERAL COUNSEL, INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE & AGRICULTURAL IMPLEMENT WORKERS OF AMERICA, UAW

Mr. KILLEEN. Mr. Chairman, my name is Patrick F. Killeen. I am assistant director of the Social Security department of the International Union, UAW. With me today is Alan Reuther, associate general counsel of the UAW. I appear before you today on behalf of some 1.5 million active and retired members of the UAW and their families.

The UAW commends this subcommittee for holding hearings on the inclusion of outpatient prescription drugs under Medicare as part of a package to protect elderly and disabled beneficiaries from catastrophic medical costs. Our union strongly supports the coverage of prescription drugs under Medicare.

Mr. Chairman, the absence of a prescription program results in out-of-pocket costs of catastrophic proportion to large numbers of Medicare beneficiaries with medical conditions requiring expensive medication. We appreciate this opportunity to appear before you today to describe the kinds of outpatient prescription drug programs the UAW has established in collective bargaining and to discuss the potential applicability of our experience to Medicare.

The UAW first negotiated outpatient prescription drug coverage on a major scale in the mid-1960s negotiations in the automobile, aerospace and agricultural implement industries. The program is a service benefit, by which covered individuals receive payment in full, minus any specified copayments, while receiving medications from practicing pharmacies. It covers Federal legend drugs and insulin for diabetics.

From the beginning, participating pharmacies have been reimbursed on the basis of the acquisition cost of the drug—the whole cost to the pharmacy—plus a modest dispensing fee to allow for pharmacy overhead and profit. There is no deductible nor coinsurance. A patient copayment per prescription is typical as a result of collective-bargaining compromise.

In recent years, the UAW has developed programs which promote substitution of generic equivalent drugs, where appropriate, by pharmacists in order to contain costs while maintaining quality.

This full service type of prescription drug program has been very successful in delivering benefits for needed medications in a cost effective way. And it has been extremely popular among the UAW membership.

In spite of such success, however, we have continued to look for new and better ways of serving our membership. In recent years, we have successfully implemented mailorder prescription drug programs at many of the major corporations employing UAW members. UAW approved mailorder drug firms achieve significant savings by efficient, large volume operations, by routine generic substitution, and by virtue of the fact that the pharmacy does not have to be in a high cost commercial location.

Another way of delivering a prescription drug benefit is to contract with an organization which has put together a limited network of participating pharmacies. These pharmacies agree to accept lower dispensing fees in exchange for increased volume. Additional cost savings result from generic substitution and bulk purchasing of drugs by the organization.

Another type of program is the so-called major medical indemnity approach to prescription drug coverage. This approach, however, has serious drawbacks. Patients are required to save the receipts for their prescription drug expenses and submit them to the insurance carrier after a deductible of a certain dollar amount has been exceeded. This type of program has extremely high administrative costs in relation to the benefits delivered because of the inefficient processing of so many pieces of paper. Compare this to the service benefit arrangement where, quite often, participating pharmacies have direct computer linkage to the carrier.

Furthermore, the reality is that under the major medical approach, with patient involvement in claims processing and maintenance of records, many people simply do not receive the benefits to which they are entitled.

At the present time, the UAW is involved in two pilot programs which this subcommittee may find of interest. The first is a prescription drug utilization review program at certain General Motors locations. The program monitors for contraindicated medications, for medications prescribed by one physician which may be harmful to the treatment efforts of another physician treating a different condition, and other prescribing anomalies. Direct feedback to pharmacies and physicians is a key element.

Mr. Chairman, I believe the UAW experience indicates that it is possible to establish a program of outpatient prescription drug coverage under Medicare which is affordable, with predictable benefit expenditures and relatively inexpensive administrative costs, and which would promote the quality of medical care. Our experience demonstrates the feasibility of a full-service program, and it also provides lessons for rational design of a more limited program, if such is necessary in light of available government resources.

For example, a program could be designed to cover maintenance drugs for chronic medical conditions. This would provide protection for those experiencing catastrophic annual prescription drug costs as the result of having to take several expensive medications on an ongoing basis. This could perhaps best be done in conjunction with a mailorder program.

The UAW strongly recommends against the adoption of a major medical approach for the reasons stated earlier: High administrative costs and loss of benefits due to involvement of patients in claims processing and recordkeeping.

In order to promote the quality of medical care, the UAW also recommends that any prescription drug program contain utilization review programs which include patient and physician profiles and which attempt to identify specific problems and aberrant prescribing patterns.

Generic substitution should be built into a prescription drug program from the beginning to conserve scarce program resources.

We also would suggest that the government explore selective contracting with provider organizations which would bid to provide benefits through pharmacy networks, perhaps on a geographic basis.

In conclusion, Mr. Chairman, the UAW appreciates the opportunity to share some of our thoughts and experiences with you. We are prepared to work with this subcommittee to help develop a most needed outpatient prescription drug program for the elderly and disabled Medicare beneficiaries.

Thank you.

[The prepared statement follows:]

## Statement of
## Patrick F. Killeen
## Assistant Director, Social Security Department
## International Union, UAW

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The UAW commends this Subcommittee for holding hearings on the inclusion of outpatient prescription drugs under Medicare as part of a package to protect elderly and disabled beneficiaries from catastrophic medical costs. Our Union strongly supports the coverage of prescription drugs under Medicare. The absence of a prescription program results in out-of-pocket costs of catastrophic proportion to large numbers of Medicare beneficiaries with medical conditions requiring expensive medication. We appreciate this opportunity to appear before you today to describe the kinds of outpatient prescription drug programs the UAW has established in collective bargaining and to discuss the potential applicability of our experience to Medicare.

### UAW Experience

The UAW first negotiated outpatient prescription drug coverage on a major scale in the mid-1960s negotiations in the automobile, aerospace and agricultural implement industries. At that time many doubted such a program could be successfully designed, since outpatient prescription drugs did not fit the "classic insurance model." In fact, we recognized this departure from the classic insurance model by building specific cost control features into the design of the program from the outset. The program is a "service benefit," by which covered individuals receive payment in full, minus any specified copayments, when receiving medications from participating pharmacies. It covers federal legend drugs and insulin for diabetics. From the beginning, participating pharmacies have been reimbursed on the basis of the acquisition cost of the drug -- the wholesale cost to the pharmacy -- plus a modest dispensing fee to allow for pharmacy overhead and profit. There is no deductible nor coinsurance. A patient copayment per prescription is typical as a result of collective bargaining compromise. Normally a patient can receive up to a 34 day supply of a drug, with renewals requiring an additional copay.

There is provision for supplying up to 100 or 200 unit doses of certain maintenance drugs for treatment of chronic medical conditions. This is both more convenient to the patient and results in fewer out-of-pocket copays. It also results in fewer dispensing fees to pharmacies, thus helping to hold down costs.

In recent years, the UAW has developed programs which promote substitution of generic equivalent drugs, where appropriate, by pharmacists in order to contain costs while maintaining quality. We began with a very limited number of drugs in select locations, and have expanded the lists of drugs and the number of geographic areas, building upon our early success.

This full service type of prescription drug program has been very successful in delivering benefits for needed medications in a cost effective way. And it has been extremely popular among the UAW membership.

In spite of such success, however, we have continued to look for new and better ways of serving our membership. In recent years, we have successfully implemented mailorder prescription drug programs at many of the major corporations employing UAW members. UAW approved mailorder drug firms achieve significant savings by efficient, large volume operations, by routine generic substitution, and by virtue of the fact that the pharmacy does not have to be in a high cost commercial location. Savings are shared with patients through a lower copay per prescription and by allowing for a larger supply of drugs per refill (typically 90 days), a sensible approach since most of the drugs dispensed are for long term use. The mailorder program is also more convenient, especially for many of the disabled or infirm, because it eliminates frequent trips to the pharmacy.

The UAW requires approved mailorder drug programs to promote quality by maintaining a profile on prescription drug use for each individual, thereby identifying cases where the use of certain drugs in combination may be contraindicated, as sometimes happens when individuals are treated for different medical conditions by different medical specialists.

Another way of delivering a prescription drug benefit is to contract with an organization which has put together a limited network of participating pharmacies. These pharmacies agree to accept lower dispensing fees in exchange for increased volume. Additional cost savings result from generic substitution and bulk purchasing of drugs by the organization. Specified quality standards are part of the pharmacy contract. For example, patient profiles are maintained to avoid contraindicated medications. The UAW has established one such program with Ford Motor Company in Michigan and we are in the process of evaluating the experience. In this case, the contracting organization is paid on a capitation basis, and thus assumes the financial risk for program costs.

Another type of program is the so-called "major medical" indemnity approach to prescription drug coverage. This approach, however, has serious drawbacks. Patients are required to save the receipts for their prescription drug expenses and submit them to the insurance carrier after a deductible of a certain dollar amount has been exceeded. This type of program has extremely high administrative costs in relation to the benefits delivered because of the inefficient processing of so many pieces of paper. Compare this to the service benefit arrangement where, quite often, participating pharmacies have direct computer linkage to the carrier. Furthermore, the reality is that under the major medical approach, with patient involvement in claims processing and maintenance of records, many people simply do not receive the benefits to which they are entitled.

At the present time, the UAW is involved in two pilot programs which this Subcommittee may find of interest. The first is a prescription drug utilization review program at certain General Motors locations. The program monitors for contraindicated medications, for medications prescribed by one physician which may be harmful to the treatment efforts of another physician treating a different condition, and other prescribing anomalies. Direct feedback to pharmacies and physicians is a key element. We are in the process of evaluating what we believe will be a very valuable quality promotion program.

Another pilot program is being implemented at several GM locations whereby pharmacists are given an incentive to substitute generic equivalents through a payment formula which allows them to share in the savings.

## Potential Implications for Medicare

Mr. Chairman, I believe the UAW experience indicates that it is possible to establish a program of outpatient prescription drug coverage under Medicare which is affordable, with predictable benefit expenditures and relatively inexpensive administrative costs, and which would promote the quality of medical care. Our experience demonstrates the feasibility of a full-service program, and it also provides lessons for rational design of a more limited program, if such is necessary in light of available government resources.

For example, a program could be designed to cover maintenance drugs for chronic medical conditions. This would provide protection for those experiencing catastrophic annual prescription drug costs as the result of having to take several expensive medications on an ongoing basis. This could perhaps best be done in conjunction with a mailorder program.

The UAW strongly recommends against the adoption of a major medical approach for the reasons stated earlier: high administrative costs and loss of benefits due to involvement of patients in claims processing and recordkeeping.

In order to promote the quality of medical care, the UAW also recommends that any prescription drug program contain utilization review programs which include patient and physician profiles and which attempt to identify specific problems and aberrant prescribing patterns.

Generic substitution should be built into a prescription drug program from the beginning to conserve scarce program resources.

We also would suggest that the government explore selective contracting with provider organizations which would bid to provide benefits through pharmacy networks, perhaps on a geographic basis.

In conclusion, Mr. Chairman, the UAW appreciates the opportunity to share some of our thoughts and experiences with you. We are prepared to work with this Subcommittee to help develop a most needed outpatient prescription drug program for the elderly and disabled Medicare beneficiaries.

Thank you.

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Chairman STARK. Thank you very much.

Mr. Needham?

## STATEMENT OF THOMAS A. NEEDHAM, R.PH., PHARMACEUTICAL CONSULTANT, BLUE CROSS & BLUE SHIELD OF MICHIGAN

Mr. NEEDHAM. Mr. Chairman and members of the subcommittee, I am Thomas A. Needham, pharmaceutical consultant with Blue Cross & Blue Shield of Michigan. I am pleased to be here today to provide the subcommittee information on our experience with coverage of outpatient prescription drugs.

Blue Cross & Blue Shield of Michigan currently provides health coverage to 4.8 million people. The plan provides group health insurance for the major automotive accounts, which include over 3 million members. Approximately 2.8 million of our members have prescription drug coverage, including 313,432 Medicare beneficiaries with employer group coverage. Our prescription drug program is one of the largest in the Nation.

Chairman STARK. Mr. Needham, could I interrupt?

Is the plan that you are administering the same as Pat's plan? Do these guys administer your plan?

Mr. KILLEEN. Blue Cross & Blue Shield of Michigan is the control plan for auto; General Motors, Ford, and Chrysler.

Chairman STARK. So it's similar?

Mr. KILLEEN. Yes.

Chairman STARK. So the statistics that you are going to use in your testimony have some bearing on what you have just testified to.

Do you like what they are doing?

Do they do a good job?

Mr. KILLEEN. Yes.

Chairman STARK. OK.

All right, go ahead, Mr. Needham.

Mr. NEEDHAM. Our prescription drug coverage is combined with other health benefits in the packages we offer our group customers. We do not market prescription drug policies separately, nor do we offer this coverage to our nongroup enrollees.

Our program covers all drugs that, under federal law, require a written prescription by a physician and that have been approved by the Food and Drug Administration. This excludes all over-the-counter medications which can be obtained without a prescription such as aspirin and patent cold remedies.

The prescription drug program we offer our group customers may be purchased with or without a copayment requirement. Under a copayment arrangement, the member is responsible for a portion of the prescription cost. Currently, all of our customers require copayments. The copayment requirement varies according to the preference of the group purchasing the prescription drug program for its employees. Whatever amount is selected, it applies to all members in a specific group. The average copayment is $3.50 with none exceeding $5 per prescription or refill.

The cost of prescription drug benefits paid by Blue Cross & Blue Shield of Michigan have been rising rapidly. In 1980, a total of $120 million was paid. By 1986, this amount almost tripled with $311 million being paid for prescription drugs, including $79 million for retiree drug benefits. In 1 year alone, spending increased by 21 percent from $257 million in 1985 to $311 million in 1986. About half of this 1986 increase was associated with increases in drug prices with the remainder for increases in the number of drugs prescribed.

Chairman STARK. Do you have any statistics as to whether or not that increase is for the same drug, or is this new drug replacing an older drug at a higher price?

Mr. NEEDHAM. There are several reasons for the higher cost.

Chairman STARK. If half the 21 percent is from prices, are drug prices going up 10 percent a year—just standard drugs without any changes?

It is very helpful. I so envy you guys. Imagine, you two guys sitting down with a couple of guys from General Motors and hammering out a deal. No input from your membership, none from the pharmacists, none from the drug manufacturers; you guys just hammer out a deal, shake hands, get a vote, and it's done—bang. I love it. It must be so easy to establish these benefit plans.

But what is most helpful are some of these numbers, and I hope you could submit these statistics to the committee. What you have said is what we have suspected and what everybody else has testified: your average retiree spending is $300; $6 or $8 billion for us.

So the $300 is out of range; we do not have the money. How many people pop up above that level on the graph, and how high? That is the population when we talk about catastrophic—not about a retirement benefit. I would love to expand the benefits $300 a year for our 30 million, but that cannot be, we do not have it.

If we had a billion, would that be worth doing? You would certainly have a better handle on it. How many people do we pick up, and how really catastrophic is that cost? Is it much more difficult to do what you have done. You did not have to get the pharmacists to agree, you had the money; you want to play in our ballpark, sign up as a preferred provider, or you don't get it.

We do not have that luxury in a democracy. Our program would have to be somewhat broader, although I suppose we could implement something like that. But is it worth the politics and trouble bringing everybody in, or is there another way we could just pass out the billion dollars to expand Medicaid, and do as much good.

If I could just get from you the outliers, some kind of a sampling of those people who go above the average, and how often does that occur within your population? That is the kind of thing that I think would be of some use to us.

Mr. NEEDHAM. I do not have the numbers.

Chairman STARK. But you could compute them, I suspect, out of your statistics.

That would be very helpful to us.

[The prepared statement follows:]

## Statement of Thomas A. Needham, Pharmaceutical Consultant, Blue Cross and Blue Shield of Michigan

Mr. Chairman and Members of the Subcommittee, I am Thomas A. Needham, pharmaceutical consultant with Blue Cross and Blue Shield of Michigan. I am pleased to be here today to provide the Subcommittee information on our experience with coverage of outpatient prescription drugs.

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In the early days of health insurance, the cost of prescription drugs was not a significant part of health care expenditures. Rather, it was considered a more budgetable item that could be paid out-of-pocket. However, the growing use of drug therapy in the treatment of disease and the high cost of many new products has led to greater amounts being spent on drugs. In the late 1960's, only one percent of benefit expenditures was covered under existing health insurance policies, mainly through major medical coverage, and there was an increasing demand for a program which would cover prescription drugs. As a result in October 1969, Blue Cross and Blue Shield of Michigan introduced its prescription drug program.

Our prescription drug coverage is combined with other health benefits in the packages we offer our group customers. We do not market prescription drug policies separately nor do we offer this coverage to our non-group enrollees.

### Benefits

Our program covers all drugs that, under federal law, require a written prescription by a physician and that have been approved by the Food and Drug Administration. This excludes all over-the-counter medications which can be obtained without a prescription such as aspirin and patent cold remedies. The only exception is injectable insulin, which although sold "over-the-counter" is covered because of its life and death importance to a person suffering from diabetes.

Prescriptions ordered by a Doctor of Medicine, Osteopathy, Podiatry, Dental Surgery or Dental Medicine who is legally licensed to prescribe medication are acceptable under the program. Telephone prescription orders are acceptable in accordance with existing pharmacy laws.

### Copayments

The prescription drug program we offer our group customers may be purchased with or without a copayment requirement. Under a copayment arrangement, the member is responsible for a portion of the prescription cost. Currently, all of our customers require copayments. The copayment requirement varies according to the preference of the group purchasing the prescription drug program for its employees. Whatever amount is selected, it applies to all members in a specific group. The average copayment is $3.50 with none exceeding $5.00 per prescription or refill. We are also now discussing an arrangement whereby a group's subscribers would be liable for between 10 to 20 percent of the prescription price rather than a specific dollar amount per prescription.

### Participating Providers

Our program relies heavily on the participating provider concept. A participating pharmacy is one who has entered into a contract with Blue Cross and Blue Shield of Michigan and who has agreed in writing to:

1. Charge a prescription drug member no more than the copayment amount for a covered drug, and
2. Accept reimbursement from Blue Cross and Blue Shield of Michigan as payment in full. This payment is the sum of the "acquisition cost" plus the "dispensing fee" and minus the copayment. The "acquisition cost" is the price the pharmacist actually paid for the prescription and the "dispensing fee," currently set at $3.50 for each prescription, is to compensate the pharmacist for dispensing the drug.

Ninety-eight percent of all pharmacists in Michigan are participating providers. Reimbursement for these services is made directly to these providers by our Plan.

Non-Participating Providers
A non-participating provider under the prescription drug program is one who has not signed a participating agreement with us. This could be a provider in Michigan who has elected not to participate or a provider out-of-state who is not eligible to participate.

- Non-Participating Providers in Michigan: A member receiving a covered drug at a non-participating provider is charged for the full cost of the drug. In turn, he files a claim for reimbursement with Blue Cross and Blue Shield of Michigan. Payment goes directly to the subscriber in an amount equal to 75 percent of the usual and customary charge after the copayment has been deducted.

- Out-of-State Providers: If a subscriber goes to an out-of-state provider, he is responsible for paying the provider and seeking reimbursement from Blue Cross and Blue Shield of Michigan. Blue Cross and Blue Shield will reimburse the subscriber 100 percent of the usual and customary fee less the copayment.

Processing of Claims
Each member's Blue Cross and Blue Shield of Michigan card includes a code which indicates the specific prescription drug benefit package to which he is entitled. Every pharmacist in the state has a listing of these benefits and the specific copayment amounts required under each policy. About 90 percent of all pharmacies in the state have automated systems and calculation of the reimbursement amounts and copayment requirements is fairly routine.

Participating providers are responsible for indicating the acquisition cost on the claims they submit. Follow-up audits are conducted to assure the "acquisition" cost on the claim matches the pharmacist's invoices from manufacturers and wholesalers.

Participating providers usually send their bills to Blue Cross and Blue Shield of Michigan once a week and most are submitted electronically. It costs about fifty cents to process an average prescription drug claim. The extremely high percentage of electronically submitted claims helps to keep the administrative costs fairly low.

In 1986, Blue Cross and Blue Shield of Michigan processed 24 million prescription drug claims in an average of five days. Of these, 6 million belonged to Medicare beneficiaries. The average number of prescriptions filled per person in 1986 was 7.4. For the retiree segment, it was 20.0, almost three times as many. The cost of an average prescription was $12.84 and the average cost per retiree prescription was $15.60, 22 percent higher.

Rising Cost of Prescription Drug Program
The cost of prescription drug benefits paid by Blue Cross and Blue Shield of Michigan have been rising rapidly. In 1980, a total of $120 million was paid. By 1986, this amount almost tripled with $311 million being paid for prescription drugs, including $79 million for retiree drug benefits. In one year alone, spending increased by 21 percent from $257 million in 1985 to $311 million in 1986. About half of this 1986 increase was associated with increases in drug prices with the remainder for increases in the number of drugs prescribed.

Alternative Cost Containment Prescription Programs
Obviously, both the Plan and our customers were alarmed at this huge rate of increase. As a result the Plan has developed a variety of cost containment measures in addition to the standard copayment option. Blue Cross and Blue Shield of Michigan offers several alternative programs for employer groups to choose from:

-- Maximum Allowable Cost: The prescription drug "maximum allowable cost" (PD-MAC) program is essentially the same as the standard program just described, except that it mandates drug product substitution of certain lower cost generically equivalent drugs. Otherwise the benefit structure and reimbursement arrangements are the same. About 1.4 million members -- about half of all subscribers with drug coverage -- have the PD-MAC program. We estimate that this program saved $14.6 million in 1986.

In developing this program, Blue Cross and Blue Shield of Michigan commissioned an independent group of pharmacists to compile a list of generic drugs that could be appropriately substituted for more expensive name brand products. This group meets periodically. Currently, there are 116 drugs on this list. For every drug in this program, a pharmacist must use the generic substitute in filling the prescription unless the more expensive product is specifically authorized by the physician. Once an employer chooses this option, it is mandatory for all participants.

-- Pharmacist Incentive Program: Another option to encourage generic substitution is the pharmacist incentive program. Under this program, the list of generic substitutes is expanded to 200 multisource drugs. The pharmacy is reimbursed 50 percent of the difference between a "target price" and the acquisition cost, if lower. The "target price" represents the average acquisition cost for a particular drug for all pharmacists in an area. Instead of mandating the substitution, this program provides an incentive for the pharmacist to dispense the lower priced substitute.

-- Preferred Provider Organization
The Blue Cross and Blue Shield of Michigan just recently began a "preferred provider" option called the "alternative prescription drug program." It uses selective contracting based on cost, quality and other performance measures to determine which pharmacies can participate. If a member goes to a pharmacy that does not participate in this program, the Plan will reduce the payment amount to 75 percent of the prescription's cost.

This program includes a drug utilization review component which monitors providers and subscribers prescription drug patterns. The Plan will be profiling pharmacists' acquisition costs and comparing them with other pharmacists' costs in the area and will also be examining the number of prescription drugs taken by subscribers. Efforts will be used to educate individuals whose behavior varies significantly from the norm. We are looking to use this feature in other parts of the drug program. This program also includes an expanded PD-MAC program which has lower payment screens based on "bulk purchasing" available through a cooperative pharmacy purchasing organization.

-- Other cost containment features of our program include limits on both the quantity of each prescription and the length of time after a prescription is written that a refill may be obtained. Generally, each prescription cannot exceed a 34-day supply except for maintenance drugs where 100 units or a 90-day supply may be allowed. This will limit stockpiling of drugs that may never be used. With respect to the life of a prescription, our plan policy is to limit it to one year.

Alternatives Considered
Over the past years, the Plan has studied other alternatives for reimbursing pharmacists including Average Wholesale Price and the Estimated Allowable Cost. We have looked at these types of programs in other states and have concluded that our acquisition cost methodology results in lower payments. You should also be aware that the Michigan Medicaid program uses the acquisition cost methodology as well.

In addition to a copayment, we have also considered requiring a deductible amount before which drug coverage would begin. We rejected this mechanism because we would not be able to control the price of drugs paid by our subscribers.

Conclusion
In developing a program to cover outpatient prescriptions under Medicare, I would recommend that careful consideration be given to cost control mechanisms such as the ones used in our Plan. In the State of Michigan we

are seeing rapidly escalating benefit payments and are continually seeking new innovative programs to restrain these costs.

I hope this information has been helpful and will be happy to answer any questions you may have.

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Mr. NEEDHAM. We are also in the marketing of——

Chairman STARK. But you do not also have to take into consideration the pharmaceutical manufacturers——

Mr. KILLEEN. Not to the extent that——

Chairman STARK. That we do—the retail pharmacists. Because you can set up your own, as I gather you have. I was going to ask you about that in a minute.

Mr. KILLEEN. Well, we do need retail pharmacists to agree to participate in our program.

But getting to the issue of the scarce resources, we did, in our prepared statement, suggest ways of doing that. We expressed a preference for focusing on the maintenance drugs for chronic conditions.

Chairman STARK. Is that a different way? Are you suggesting that if we are going to ration this, that rather than look to a formulary and concentrating on the side that you all talked about, pushing for generics is the first step; go to this group of experts and say, "Find us those diseases that most often have the huge expense of drugs associated with them, and start with those." As an alternative to overall costs, is that what you are suggesting?

Mr. KILLEEN. Yes.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Mr. Chairman, I will be brief.

You asked some good questions, but I am not sure what the answers were. You asked the question, based on your experience, that if there were a billion dollars to spend, could it be done or not. If you, Mr. Killeen, were here instead of there, knowing what you know, what would your answer be?

Mr. KILLEEN. Well our answer clearly would be——

Mr. LEVIN. Now that is including it within a catastrophic bill. A billion dollars, more or less, and not a comprehensive prescription drug plan in Medicare; but a plan that is built into catastrophic so it has some time to go to a threshold, et cetera.

The chairman's question is, knowing what you know and with the experience that you have.

Would you list certain ailments for certain drugs? How would you proceed?

Mr. KILLEEN. I would suggest again that program is best constructed by covering certain maintenance drugs used to treat chronic medical conditions and focus in on a list of those drugs, take care of the greatest expenses, the individuals with the greatest expenses.

Mr. LEVIN. Thank you, Mr. Chairman.

Chairman STARK. I just wanted to welcome our ranking member, who has been busy doing the Lord's work over at the Republican conference.

If some of the witnesses are in the room as we have the last panel, he may want to throw some questions in for the witnesses that remain.

I just want to try one more pass at this. I don't want to misstate or misinterpret your testimony. I want to say this in the broadest general terms.

What the two witnesses here have talked about is really a comprehensive way to provide pharmaceuticals to retired folks, and kind of manage the plan. It's as if they were in an HMO which included all pharmaceuticals. But we do not have the $8 billion—$10 billion rather, because of the increased usage—to be realistic about implementation. Maybe we have $1 billion.

Now the question is, do we ration some kind of copay with a dollar threshold; spread $1 billion among our 30 million beneficiaries, then have a panel that would compound a cost containment formulary? Or do we concentrate on a disease, a drug, a few common illnesses among the elderly which would probably be arthritis, hypertension and ulcer, say "Let's just take those." Those are the ones that your statistics might support most often because of the high cost; $1,500 average rather than $300 average, and try and attack that.

Perhaps the UAW is suggesting an alternative that this committee should consider. Is that a fair summary? I don't mean to lead you down that path.

I think your data base, in particular, would be very helpful.

Mr. NEEDHAM. Regarding the administrative costs, I might mention that Blue Cross of Delaware and the Medicaid program in Alabama utilize the direct payment approach, and it reduced the cost per prescription by two-thirds.

I think you're well aware that the prescription drug program, although it accounts for a little more than 6 percent of the Medicaid program, accounts for the high part of 40 percent of the administrative costs and associated paperwork.

One recent study on the subject projected that had Medicaid adopted the voucher or direct payment approach in 1985, it would have saved approximately $75 million or in a five-year period, $400 million solely in administrative costs.

The other area of administrative costs, that we have always found somewhat ironic, is the companies that manage the Medicaid program in certain states are guaranteed a net profit of 12 percent. Our people work on 3-percent profit.

Chairman STARK. Before we hear Mr. Donoho, I think we will go vote.

[Short recess.]

Chairman STARK. The committee will continue, and we will hear from Mr. Donoho.

## STATEMENT OF PATRICK DONOHO, DIRECTOR, GOVERNMENT RELATIONS, REVCO DRUG STORES, INC., FOR THE NATIONAL ASSOCIATION OF CHAIN DRUG STORES

Mr. DONOHO. Mr. Chairman, I am Patrick Donoho of Revco, Drug Stores, Inc.

We would like to submit for the hearing record our comments to the Health Care Finance Administration proposed prescription drug reimbursement guidelines. These guidelines provide a comprehensive view of the present reimbursement structure and present some alternative views.

We appreciate the opportunity to testify before the subcommittee today. Thank you.

[The prepared statement follows:]

Statement of Patrick Donoho, on Behalf
of the National Association of Chain
Drug Stores, Inc.

## INTRODUCTION

Mr. Chairman, my name is Patrick Donoho and I am Director of Government Affairs for Revco, D. S., Inc. My statement this morning is presented on behalf of the National Association of Chain Drug Stores, Inc. We deeply appreciate the opportunity to testify on the issue of Medicare and prescription drug benefits. Our statement will not address the financing of a drug benefit package, but will focus on what we believe would be a model drug reimbursement system.

NACDS is a non-profit trade organization, founded in 1933, which represents the management of 171 chain drug corporations that are operating close to 20,000 retail drug stores and pharmacies throughout the United States. Collectively, our members were responsible for $30 billion in retail sales in 1986 and more than 540 million prescriptions were dispensed to patients by corporate drug chains during this same period. Also, 50,000 pharmacists practice their profession for our member companies.

Members of the National Association of Chain Drug Stores, Inc., range in size from operations with only four stores to companies with more than 1900 retail outlets. Thus, our testimony reflects the views of both small businesses and large corporate entities. We commend the Chairman for holding this hearing which addresses a very important health care issue, namely drug benefits for the Medicare program.

Essentially, the recommendations that we are putting forth in our testimony today are the same sound principles that NACDS and its corporate members have previously advocated to Congress and the Administration in 1986 on reforming drug reimbursement for Federally assisted health care programs, such as Medicaid and Medicare.

On October 24, 1986, NACDS provided testimony to the House Select Committee on Aging on the issue of "High Drug Costs and Older Americans: A Prescription for the Future."

In our statement to the Select Committee on Aging, we expressed our concerns over the escalating costs of prescription drugs and the hardships that these increases have on individuals who can least afford to pay for their medications. NACDS discussed the documented increases in pharmaceutical prices from manufacturers that are going upward at nearly twice the rate of other commodities in the Consumer Price Index (CPI). We further noted that outdated Federal policies governing drug reimbursement have been a major contributing factor to the price increases we have seen from pharmaceutical companies. In addition, our statement showed that these same Federal policies have resulted in cost-shifting among retail pharmacies to private pay patients and the elderly to compensate for inadequate reimbursement rates under Medicaid.

## MAC PROGRAM IS NOT WORKING

Mr. Chairman, in our opinion, one of the most significant reasons for the troublesome rise in drug costs in recent years is the Department of Health and Human Services' (HHS) so-called Maximum Allowable Cost (MAC) program developed and implemented more than a decade ago, the MAC reimbursement policies are complicated, cumbersome and fail to take advantage of the competitive marketplace. Under this current system, pharmaceutical companies essentially have an open-ended account with the Federal Government. Manufacturers receive full payment for whatever price the company charges the Medicaid program while the narrow focus of the MAC regulations has been to suppress and excessively regulate drug prices at the retail level. With the exception of a few multi-source products, there is no competition or cost-containment features to encourage manufacturers to control prices under the MAC regulation, and consequently, it is not uncommon to see several price increases by brand-name companies for their product lines each year. In stark contrast, these same Federal policies provide no incentive for pharmacy providers to offer less costly generic drugs to needy recipients, fail to cover even the basic costs of doing business with Medicaid and totally ignore the importance of encouraging program savings through competition in the retail environment.

As a result, manufacturers' prices continue unabated on an upward trend affecting all consumers, especially the elderly, while drug stores tug and pull to justify staying in the Medicaid program. Retail pharmacies are forced to adjust to compensate for inadequate reimbursement rates under Medicaid by cost-shifting these transaction losses over to the cash-paying customer and the elderly. In essence, the private pay patient is helping to subsidize Medicaid.

While Medicaid and the current regulatory scheme is not entirely at fault for the cost-shifting phenomena, Medicaid is clearly the worst offender among third party payer reimbursement programs. Two recent studies found that private pay customers, on the average, pay a subsidy of $.52 per prescription because of inadequate Medicaid reimbursement rates. Considering that, on the average, our nation's elderly receive 12 prescriptions a year, the aged who can least afford medications are having to pay an additional minimum of $6.00 in hidden subsidies as a result of Medicaid's flawed reimbursement system.

## MEDICAID NEEDS REFORM -- MARKETPLACE COMPETITION

To help remedy this unfair problem of cost-shifting and to bring other critically needed reforms to Federal health care programs that will promote program savings, we recommended to the Department of Health and Human Services (HHS) a major revamping of the regulatory system that governs drug reimbursement. Specifically, NACDS has put forth a very sensible proposal that will streamline the Medicaid program and is flexible enough to keep pace with all the changes that are taking place in the marketing of prescription drugs, particularly the new influx of generics that is occurring as a result of Congressional enactment of the Drug Price Competition and Patent Term Restoration Act of 1984 (P. L. 98-417). We firmly believe that our proposal for a new reimbursement system will capture substantial program savings through competition, less regulation, ease of administration and the increased dispensing of less costly generic drugs. To a great degree, our recommendations will promote competition at all levels of the drug distribution system including manufacturers so that a more concerted effort to control costs will result.

Under our approach, which is a modification of the Health Care Financing Administration's (HCFA) own Competitive Incentive Program (CIP) proposal, we are recommending that Medicaid drug reimbursement be governed by marketplace pricing. Simply stated, generic drugs would be reimbursed based at the pharmacy's full marketplace price and reimbursement for the leading brand-name drugs that have three or more generic equivalents would be at the pharmacy's marketplace price capped at the 75th percentile of all charges within the state. We are certain that with a Federal policy which carefully and prudently differentiates between generics and brand-name products with respect to retail reimbursement rates, there will be a greater economic incentive for pharmacies to dispense generic versions when permissible and possible. Non-multiple source drug products (i.e. sole source drugs or products which have fewer than three suppliers) would be reimbursed at the marketplace price capped at the 90th percentile under our recommendation to HCFA.

## PROGRAM SAVINGS WITH BALANCED TREATMENT OF GENERICS

In our opinion, this reimbursement approach will provide for a more balanced treatment of brand-name and generic drugs than the current system offers, and the Medicaid program will realize significant program savings as a result of the increased utilization of generics which are 30 to 70 percent less expensive than brand-name prescriptions. Furthermore, we believe that our proposal will greatly stimulate competition among pharmaceutical companies. With generics competing more equally with their brand-name counterparts, pricing schedules will adjust accordingly as suppliers are challenged by vigorous marketplace forces. On the subsidy issue, because Medicaid drug reimbursement would be based on the most competitive price that retail drug stores offer cash-paying customers, the cost-shifting that we discussed earlier impacting upon the elderly would be minimized because pharmacies would be reimbursed at a fair rate. Thus, by overcoming the cost-shifting problem associated with Medicaid, the private pay customers and the elderly, as well as recipients, will benefit as we ratchet down this vicious cycle. Since many third-party programs tend to follow Medicaid policies, the subsidy issue is once again reduced even further.

For the Subcomittee's review, we can make available a copy of our complete 33-page statement to reform and improve the Medicaid program which was submitted to HCFA on October 8, 1986.

## UNIFORM CLAIMS PROCESSING -- ELECTRONIC DEBIT CARDS

Aside from the importance of relying on competition and promoting generic drugs as an effective cost-savings feature for Federal health care programs, corporate drug chains have repeatedly espoused the benefits of establishing a uniform claims processing system through an electronic debit card approach. The technology is here and is perfect for prescription claims processing, eligibility verification, maintaining patient records and paying promptly on reimbursement. We raised this issue in testimony to Congress in April of 1986 along with the National Association of Retail Druggists (NARD) and the American Pharmaceutical Association (APhA). NACDS is confident that an electronic debit card system for Medicaid could reduce administrative costs by at least $43 to $60 millior annually. If you factor in other savings features of this system, especially recipient eligibility, the savings are much greater. We also called for the establishment of electronic debit cards in our formal comments to HHS and HCFA on October 8, 1986.

For whatever reason, HCFA is reluctant to move forward on this recommendation for Medicaid and blocked an attempt to implement one in Montana just last month. Thus, we hope that our testimony today will, among other things, perk the interest of the Congress with respect to our ongoing frustrations with Medicaid so that these same problems and ill-advised policies which we have identified will be avoided under Medicare and Catastrophic coverage for prescription drugs.

## NACDS POSITION ON MEDICARE

NACDS is inclined to support drug benefits for Medicare, and it is our position that all prescription drugs should be included under this benefit for the elderly. To this end, we believe that the competitive marketplace is the preferred and only mechanism for delivery of drug benefits. Our corporate members strongly recommend that the Congress not adopt the ill-conceived policies which are currently governing the Medicaid program and to a great degree are unwisely perpetuated in many state Pharmaceutical Assistance To The Aged Programs. All of these approaches utilize artificial controls and complex regulatory formulas for reimbursement while ignoring the strengths and advantages of retail competition.

In our view, the Congress has a unique opportunity to fashion a meaningful and cost-effective drug benefit, and we urge the adoption of the following. NACDS recommends that reimbursement should be based on marketplace pricing, which is a retail pharmacy's actual price. We urge that the actual price be capped at the 90th percentile of all charges in the state for the same prescription.

NACDS further recommends that the drug benefit under Medicare should promote the utilization of less costly generics. We, therefore, support a one-line signature form or a co-payment when a brand-name drug is dispensed. Our corporate members further endorse uniform claims system for ease of administration and we believe that this approach can best be done with electronic debit cards. Finally, in light of the high deductible for drugs which would be established under this type of legislation, NACDS favors direct patient reimbursement.

On behalf of the 171 corporations which are members of the National Association of Chain Drug Stores, Inc., we appreciate the opportunity to present our industry's views on this very important health care initiative.

Thank you.

/kar

Chairman STARK. Mr. Rector.

### STATEMENT OF JOHN M. RECTOR, GENERAL COUNSEL AND VICE PRESIDENT FOR GOVERNMENT AFFAIRS, NATIONAL ASSOCIATION OF RETAIL DRUGGISTS

Mr. RECTOR. Mr. Chairman, members of the subcommittee, I am John M. Rector. I serve as general counsel and vice president of Government Affairs for the National Association of Retail Druggists.

[The prepared statement follows:]

# STATEMENT OF JOHN M. RECTOR
# BEFORE THE HOUSE WAYS & MEANS
# SUBCOMMITTEE ON HEALTH
# APRIL 23, 1987

Mr. Chairman, Members of the Subcommittee:

I am John M. Rector. I serve as General Counsel and Vice President of Government Affairs for the National Association of Retail Druggists.

The National Association of Retail Druggists represents the owners of nearly 30,000 independent pharmacies, where more than 75,000 pharmacists dispense 70 percent of the nation's prescription drugs. Together, they serve 18 million persons daily and provide 82 percent of Medicaid pharmaceutical services. Over 60 percent of NARD's members provide home health care pharmacy services.

NARD members are primarily family businesses. They have roots in America's communities. The neighborhood independent druggist typifies the reliability, stability, yet adventuresomeness that has made our country great.

As owners, managers and employees of independent pharmacies, our members are committed to legislative and regulatory initiatives designed to provide them a fair chance to compete. We appreciate the opportunity to appear before the Subcommittee to present recommendations to be considered in the fashioning of Medicare Part B outpatient drug coverage and to participate as a member of the reaction panel for today's hearing.

We believe that a major strength of the health care system is the thousands of independent community pharmacies readily accessible to virtually every segment of the population. Any revisions in the Medicare and Medicaid health care program should capitalize on the strengths of the existing retail distribution network for drugs, and related products and services.

Competition in retail pharmacies is alive and well. Competition is an incentive for efficiency and the price competition in retail pharmacy is typically greater than can be found among other providers of health services and products.

We approach the subject of today's hearing with considered reluctance. Not because we oppose the concept, in fact we support it. Our statement of positions addresses it as follows:

> "NARD supports the position that any national health insurance program adopted by the Congress include outpatient medications as an integral part of its benefits. Patients participating in these programs also must be ensured that they will have the right to select the pharmacist and pharmacy of their choice to obtain their prescription drugs. Pharmacies providing prescription medications should be compensated on the basis of the marketplace price for such products and services. Independent retail pharmacists should be assured a key role in the planning and development of any such drug program."

The source of our caution is predicated on the less than favorable experience that our members have had from the outset with the non-statutory Medicaid prescription drug program, and in recent years with the home health components of the Medicare program. We are concerned that a Medicare outpatient drug benefit program not replicate unsatisfactory aspects of the current Medicaid prescription drug program. Likewise, with more than 60% of our members involved with Medicare home health, it is critical that an outpatient drug coverage benefit be designed in a manner that will avoid the scandalous failure of Medicare to pay its participating providers in a timely business-like manner, and avoid the constant barrage of arbitrary and inconsistent regulations dictated by HCFA.

More sophisticated aspects of program design become secondary, or even irrelevant, if when operational, appropriate resources are available or if, as has been the policy of the current Administration, the government refuses to pay its bills promptly. Additionally, program continuity and stability is vitally important.

Fortunately, these especially severe Medicare cash flow problems, caused by the failure of HCFA and its agents to make timely payments, were addressed in the Omnibus Budget Reconciliation Act (OBRA) of 1986 by requiring that claims submitted for Medicare Part B Services, be paid within 30 calendar days in FY 1987, 26 days in 1988, 25 days in 1989, and 24 days in FY 1990 and in subsequent years. We strongly support the Subcommittee's initiatives on prompt payment, and as a member of the Prompt Payment Coalition, urge you to oppose all efforts to repeal the 1986 amendments.

This past October our House of Delegates unanimously passed a resolution calling for the establishment by law of the Medicaid prescription drug program reforms it has been advocating for more than a decade. Its full text is as follows:

MEDICAID

WHEREAS, Congress never intended that the normal business practices of retail pharmacy such as earned discounts or marketplace pricing be placed in jeopardy, such as under MAC, EAC, PhIP and CIP, when a pharmacist serves patients in the Medicaid program; and

WHEREAS, the concept of a government discount, whether in the form of a discount off ingredient cost of a total charge, is totally unacceptable:

BE IT RESOLVED that NARD continue to oppose the concepts of a discount and instead, together with a coalition of pharmacy practitioners, wholesalers, manufacturers and physicians, support the establishment by law of (1) marketplace pricing at the 90th percentile, and (2) a direct payment voucher system to reduce Medicaid administrative costs and assure prompt payment.

The two core themes of suggested reform: marketplace pricing and a direct payment system to reduce administrative costs and help assure prompt payments are universally supported within the industry. In fact, NACDS, PMA, ASHP, APhA, NWDA, ASCP, and NARD all endorsed a document, "Principles for Reform of Medicaid Payment for Outpatient Drugs" in correspondence to HCFA's Administrator Roper on May 26, 1986. The principles, in our view, are equally applicable to the subject of today's hearing. Unfortunately, the Administration has not embraced them fully. We have provided the subcommittee with extensive information on these core ideas including the NARD/Pracon study Marketplace Economics -- Alternatives in Medicaid Prescription Reimbursement (Oct.1986). The full text of the "principles" follows:

# PRINCIPLES FOR REFORM OF MEDICAID PAYMENT FOR OUTPATIENT DRUGS

## INTRODUCTION

Following the implementation of the Medicaid program in 1965, pharmacists, more than other provider groups, enthusiatically supported and participated in this important health care program for the needy. Ten years later, in 1975, the Federal government adopted the Maximum Allowable Cost/Estimated Acquistion Cost program. This controversial approach established a complex set of formulas that imposed artificial controls on the retail marketplace and interfered with professional judgments regarding the selection of prescription drug products provided to the poor. In more recent years, the Medicaid program has been moving toward a reimbursement scheme that would further reduce reimbursement to pharmacies.

The Federal government seems content to capture limited, short-run savings at the expense of retail pharmacy providers and the research-intensive pharmacuetical manufacturing industry, while ignoring significant opportunites for reducing health care costs by allowing the competitive marketplace to function efficiently and effectively. In response, many prominent national organizations representing all components of the nation's drug distribution system--pharmaceutical manufactureres, drug wholesalers, independent pharmacies, chain drug stores, hospitals and the pharmacy profession--have been advocating a complete overhaul of the Medicaid drug reimbursement system. These organizations are calling for less government intrustion, so that the nation's pharmacies can continue to provide the highest standard of care and service to needy people.

## FUNDAMENTAL PRINCIPLES

Reduce needless federal regulation. American society experienced a virtual explosion in Federal Government regulation during the past decades. Between 1970 and 1979 the number of pages published annually in the Federal Register nearly tripled and the number of pages in the Code of Federal Regulations increased by over two-thirds. The current Medicaid drug program was part of this growth.

Although well-intended when originally developed, the Medicaid drug program has failed to keep pace with rapid changes in health care delivery over the past ten years. This has resulted in pharmacy providers subsidizing the Medicaid program because they frequently lose money when they fill a Medicaid prescription. Moreover, the hardship and uncertaintly imposed on business by this over-regulation has impeded business decisions and expansion plans ultimately reducing economic growth and the creation of jobs in the private sector. This over-regulation is particularly burdensome to small and independent businessmen and women, such as pharmacists who are proprietors of community pharmacies, and causes them to defer or terminate plans for expansion.

Our position on Medicaid drug reimbursement is directed at minimizing governmental intrusion by reforming or eliminating regulations which are unnecessary and counterproductive.

Improve administrative practices. Approximately 171 million claims are processed each year by the Medicaid program. Wasteful administrative overhead consumes resources that should be targeted on the health care needs of beneficiaries. Furthermore, current inefficient administrative practices impose needless hardship on retail pharmacies due to slow and erratic payment, and excessive paperwork. Initiatives to imporve administrative practices can reduce both public and private costs to process Medicaid claims, and insure timely payment to pharmacies.

Rely on the marketplace. We do not need excessive Federal regulation to solve the problems of Medicaid drug costs. As long as we let the forces of the marketplace work without undue interference, the ingenuity of consumers, businesses, producers and inventors will do that for us. The retail drug market is dominated by self-pay customers who, along with increasingly cost-conscious third party payers, impose competitive discipline on marketplace prices. If we allow it to, the magic of the marketplace will unleash new competition, giving the Medicaid program lower prices, and Medicaid beneficiaries more choices and better services.

## IMPLICATIONS FOR THE MEDICAID DRUG PROGRAM

To achieve meaningful reform public policies governing the Medicaid drug program should be revised along the following lines:

- Base drug reimbursement on sound economic principles through the elimination of artificial controls. This would be achieved by replacing the current provisions governing reimbursement with marketplace pricing, i.e., usual and customary charges for all products and services, capped, for example, at the 90th percentile for all charges within a state.
- Implement a new and streamlined reimbursement mechanism that would greatly lower administrative expenses in the program. Such a worthwhile objective can be easily accomplished by coupling marketplace pricing with an innovatiove system of drug vouchers.

States shall build upon this basic set of principles established by the Federal Government, tailoring their individual programs to fit local circumstances.

Additionally, we recommend that the subcommittee seriously consider the following:

a) The reinstatement of the 60 day or longer public notice for changes in the Medicaid (Medicare) reimbursement method or level of reimbursement for the prescription drug program;

b) Interest and penalties for late payments;

c) An administrative fee for the extra cost of processing Medicaid (Medicare) forms.

d) Inclusion of both short and long term I.V. antibiotic therapy;

e) Require pharmacist consulation. Face to face communication between patient and pharmacist has been a vital component of pharmacy practice since its inception. Pharmacists interact daily with patients in their stores; they monitor their patients' health status, assess their compliance with drug therapy, answer questions, make recommendations, and communicate with their physicians. Patients know they can count on the pharmacists to provide expert advice on drug therapy on the spot and personally attend to their individualized health care needs. This interpersonal communication is an especially key element for Medicare eligible persons.

f) Reject suggestions to confiscate the discounts that pharmacists earn. Discounts extended to pharmacists on drug purchases from manufacturers or wholesalers as rewards for prompt payment, prudent purchasing, and other sound business practices are an earned portion of the pharmacist's business income. Such discounts are earned by pharmacists for operating their businesses efficiently. They serve as incentives to help a business to prosper and to continue to serve patients in the community.

g) If copayment is established, require that it be mandatory. More than 60% of our members' sales are for prescription drugs, 10-15% of our members sell only prescription drugs. They rarely "loss lead" prescription drugs and would be placed at a decided competitive disadvantage if the copay is not mandatory. Equally problematic are the copay forgiveness aspects of the Medicaid program for select beneficiary groups.

h) To address the problem of tax-exempt competitors, consider adopting provisions similar to OMB Circular A76 for bidding on federal contracts which, to assure a level playing field, requires the advantages of nonprofit status to be reflected. This could be reflected in reduced payment to nonprofits.

i) Require that manufacturers eliminate multitier pricing policies for prescription drugs, or in the alternative, permit independent retail druggists to acquire for Medicaid/Medicare purposes the drug products under the same pricing structure available to nonprofit entities.

j) Review the present reimbursement for prescription drugs under Medicare Part A with an eye to determining present cost to the government in contrast to cost in the prescription drug retail marketplace.

k) Consider, as the Energy and Commerce Committee has recommended, denying Medicaid and Medicare funds to hospitals and other health care institutions which are convicted of diverting prescription drugs.

l) Consider a provision to assure that nonprofit purchasers of prescription drugs utilized in the Medicare/Medicaid programs comply with the 1938 Nonprofit Institutions Act. This Act permits price discrimination for purchases by true charities. We recommend that an appropriate standard would be the percent of uncompensated care provided by the nonprofit entity coupled with bad debt.

m) Consider a provision that would limit physician dispensing reimbursement to rural remote circumstances where a pharmacy is not available.

n) Consider the profit guaranteed to entities that are awarded contracts to administer state Medicaid prescription drug programs when attempting to establish an appropriate level for pharmacy providers.

o) Consider the prescription drug benefit program that Marion Laboratories, Inc., Kansas City, Missouri, has established for its employees. It is based on marketplace pricing and rejects the cumbersome arbitrarily fixed dispensing fee. It reflects the variety of professional services, and importantly, it has helped contain the cost of the prescription drug benefit coverage that Marion established for its employees.

NARD seeks the support of the subcommittee for our recommendations and will assist its members and staff in the refinement of your proposals. Additionally, it is our intention to submit a supplemental statement to the subcommittee addressing several other matters relevant to your inquiry.

On behalf of the Officers, Executive Committee, and members of the National Association of Retail Druggists, we thank you for the opportunity to appear and continue to participate in the formulation of Medicare Part B outpatient prescription drug coverage.

Chairman STARK. Thank you.

Earlier, you gentlemen heard my questions on this table submitted by AARP.

Given this hypothetical senior with arthritis, hypertension, angina, ulcer and so forth, and the drugs that he would use, what if a Federal board of pharmacists and physicians—like the one in California—maintained a list that required the prescribing physician, or indeed the pharmacist, to say "No, you can't have feldine; you've got to have ibuprofen, which is $20 a hundred rather than $102 a hundred."

Would you all object to these boards? What kind of problem will we create with the pharmacies?

Mr. RECTOR. I think regarding our people, we are very familiar with that.

We are going to end up in the same situation that we are in with Medicaid.

Mr. DONOHO. I would echo that. What you are giving them is an exclusive right, a manufacturer, for a body of patients, and you have to have some sort of price constraints at that level, not at our level.

Under the present Medicaid reimbursement, we participate in almost 500 different prescription drug plans, as providers. And through all of them, there is nothing that restrains our cost increases. What it does is place a pinch on our profitability; as prices go up, our profitability goes down. So the reimbursement——

Chairman STARK. You are on a flat rate?

Mr. DONOHO. Right. A $100 prescription is not unusual today. It was extremely unusual 5 years ago. For $3, we are better off putting that money in CD's than buying the product.

Chairman STARK. Suppose I get some disease and the doctor says I have to take one aspirin an hour—forever.

Now you guys say we ought to give the guy a week's supply. As retailers, you would like to see me every week, because on the way back to your counter I'm going to buy shoelaces and toothpaste.

But absent that, is it professional or ethical for the pharmacist to participate in the administration of the prescription?

We heard what the UAW is trying to do on some of these drugs; a year's supply so the beneficiary does not have to pay the dispensing fee. They are cutting you out. They are saying, "Well, I save if I get the full gallon size, I pay only one dispensing fee. If I get the half pint size, I have got to pay a dispensing fee each time I come in."

Mr. DONOHO. Under the present system—that is why we stress the retail market. Our pricing structure is structured such that as quantities increase, the per unit costs go down. We have found over the past years, the elderly—the AARP has been successful in their operation. We are very concerned about nonprofit concerns operating in the marketplace generally. Well beyond any issues that are Medicare-related.

And given the rather intense entanglement of the nonprofit competitors in the Medicare area, one of our primary concerns is about a Medicare outpatient drug program.

There are many, many issues, not the least of which is, as you are well aware the prescription drug marketplace is permeated with what we call in the industry, armchair pricing. So that a nonprofit hospital or an HMO have access to prescription drug pricing based on so-called charity status; albeit they are nonprofits.

Chairman STARK. There is something that I have thought about that I wish you guys would address here: the hospital dispensary—or whatever you want to call the place where you get pills at the hospital. If you leave the hospital with some kind of a disease that requires a year or two of medication, we could let the hospital include the drugs in the DRG provided that the hospital dispenses at that lower rate. Some hospitals like to make money doing this.

That's going to cut your group. This has never been talked about as catastrophic.

Mr. RECTOR. I think that is part of your original question. They shouldn't design a reimbursement structure to favor one or the other; and that's why our association favors retail competition. If that is the case, the Government then decides to encourage hospital pharmacies to get into this business—all we're asking for is a level playing field.

In regards to the hospital setting issue, one company, AARP, is the second largest purchaser of pharmaceuticals in the United States, second only to the VA? There are nitroglycerin patches that we pay about $25 a box for that a hospital pays about 25 cents for that same box. The issue of volume purchasing is not the issue at all. These are "charity" buys.

Chairman STARK. Are you really saying you can't buy as effectively as the VA?

Mr. RECTOR. That's correct. We are denied access to such prices.

In the extreme are the nitroglycerin patches. One of the recommendations we have, before you move ahead with this, is to look very carefully at what Medicare is paying on inpatient hospital prescription drugs.

Chairman STARK. We're paying the same thing whether we get it from you or from the hospital.

Mr. RECTOR. You are paying significantly more in the hospital. In fact, recent testimony indicated that you are paying three and four times the average wholesale price.

Chairman STARK. Is that a marketing cost? After a stay in the hospital they come out; they've got to buy it from you; they've got a brand loyalty——

Mr. RECTOR. It started with——

Chairman STARK. It sounds to me like a marketing gimmick.

Mr. RECTOR. It started with a more altruistic basis. It started in 1938, during the Depression. It was an exception to the antitrust sanctions on price discrimination. The Non-Profit Institutions Act of 1938.

Chairman STARK. At the same time, you guys had——

Mr. RECTOR. We had gotten the Robinson-Patman Act——

Chairman STARK. What approach—fair trade.

Mr. RECTOR. That was later.

Chairman STARK. $50 Mickey Mouse watches.

Mr. RECTOR. In any case, in 1938, Congress took a look at the 1936 law, and discovered that they had constructed an eleemosynary disincentive, so they amended the Robinson-Patman Act in order to permit the kind of pricing and donations necessary for charities. Well, the world has changed. Here you have the nonprofit community in the health area, coming to your committee, asking for subsidies for uncompensated——

In our view, the uncompensated care and bad debt are the only remnants of charity that nonprofits have left in their operation. These are the sole predicates for the purchasing of the charity drugs that they get. Now, they're going to market it out in the community at retail.

Our point on that is that, fortunately the Supreme Court has held that this conduct violates the "own-use" standard. More recently, in 1983, the Supreme Court applied the same antitrust concept to State governments. It even applied it to State hospitals. The Supreme Court said that they are bound by the antitrust laws.

Unless this nonprofit competitor issue is addressed in this Medicare outpatient program, we are going to have problems. The fact is that AARP, in spite of all the outstanding things that they do for their 23 million members, is one of the principal nonprofit competitors in the prescription drug market. It is somewhat aggravating for our taxpaying members who support nonprofit activities, to see these nonprofit competitors out there not paying taxes, locating in areas of high tax bases, getting access to charity pricing, and so on and so forth.

We can supply a great deal of information for your staff's consideration about AARP, the Arthritis Foundation and others who are commercial nonprofits.

Mr. Donoho.

Chairman STARK. Eventually, if AARP has their way, we'll pay for all prescription drugs under Medicare. Obviously we ought to get the lowest price in the land.

Mr. DONOHO. Mr. Chairman, looking at the Medicaid program and the inflationary factors in the Medicaid program, that the product costs are running anywhere between 15 and 20 percent. The eligibility, enrollment figures themselves, have remained somewhat static; they aren't rising.

Chairman STARK. You say they're going up 15 to 20 percent?

Mr. DONOHO. Costs, per se.

Chairman STARK. Are going up.

Mr. DONOHO. When I first came to Revco, we had suggestions from the Michigan Medicaid program; 1981, just about everything else in Michigan at that time was going belly up. And the suggestion was made, to my company in particular, is the fact that you've got a price out there; the Government knows what they pay for the product. The Government operates health clinics; they operate state hospitals; they operate prisons; they operate the VA, a whole line of hospitals. They know what the price of the product is. They know what they're paying us, too.

That is a simple matter of math. You take that cost difference and multiply it by the number of units dispensed, and have the manufacturer send the check to the Government. They have offered both prices in both systems, and they should be willing to live with both systems.

Obviously, though, you are talking about something that is not entirely palatable to certain members of the industry.

Mr. **Rector**. We don't have any trouble with competition; it's when we get the deck stacked against us that we object.

Chairman **Stark**. Let me ask both of you—you've heard the testimony today—on the assumption of a $7 to $10 billion cost factor for Medicare beneficiaries, we might have $1 to $2 billion to spend. How would you all suggest we spend it? Should we require a deductible? Should we put it into Medicaid and buy in a little higher percentage of poverty for all Medicaid folks? What State or States, as far as you're concerned, has the best program?

Well, those are two different questions.

Mr. **Donoho**. I'll answer the second question first. It is our company's opinion that there isn't one yet.

Chairman **Stark**. Is there a lesser of the evils?

Mr. **Donoho**. That's difficult for me to say. I think that the gentleman from AARP may be correct; the proof is in the pudding, so to speak, in New York. That is yet to be determined.

I think the problem that we have with all of those types of programs, which are basically means-tested programs, is that you have demographics you are running headlong into. The funding sources for those at the State level are absolutely not there.

We had a $20 million overrun this year, in the PACE program in Pennsylvania. I don't know what the revenue sources look like this year in New Jersey.

We are at the dawning of an age, let's put it that way. Claims processing, as has been alluded to today, is in its infantile state. We are all computerized in Michigan; 90 percent of the claims processed by computer. But what we have today are banks entering into the claims processing business for prescription drugs. Prescriptions represent 50 percent of the health care claims claimed and 6 percent of the health care dollars. So you're chasing paper after pennies. What we have today is the ability, today, through a credit card system.

Our whole business has a reimbursement structure which reflects the present market; 83 percent of our consumers pay cash. We know how much it costs to treat arthritis and other diseases. You can assign that credit card that amount of value, and that person can buy those products wherever they want.

Those kinds of opportunities present themselves today. We would hope that you don't discuss this program on yesterday's news.

Mr. **Rector**. The Marion Laboratories, out in the Midwest, has developed a marketplace pricing reimbursement pharmacy program for its employees. It has been on line for several years, and it's working quite effectively in cost containment.

I know there's a tendency, when people start hearing "marketplace" to think usual and customary, everybody starts reaching for their pocketbooks. But I think if you take a careful look at the Marion program, talk to some of the Marion people, you will see that they're saving more money in the cost of their prescription drug program with this market pricing approach than they were under the traditional paperwork-heavy dispensing fee.

Chairman **Stark**. Thank you. Thank you both.

The committee is adjourned.

[Whereupon, at 11:55 a.m., the subcommittee adjourned.]

# COVERAGE OF OUTPATIENT PRESCRIPTION DRUGS UNDER MEDICARE

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## TUESDAY, JUNE 2, 1987

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
*Washington, DC.*

The subcommittee met, pursuant to notice, at 10:09 a.m., in room B-318 Rayburn House Office Building, Hon. Fortney H. (Pete) Stark (chairman of the subcommittee) presiding.

Chairman Stark. The Subcommittee on Health will begin a hearing on the coverage of outpatient prescription drugs under Medicare. The need for including outpatient prescription drugs in catastrophic coverage is clearly established.

More than 2½ million elderly spend $500 a year or more on prescription drugs. At the same time, more than half the elderly have an income of less than $10,000 a year. This $500, or money in excess of that, can be a catastrophic expense for these low-income people.

The low-income people, in particular, face a tough choice. They can spend their limited income on basic necessities or on costly drugs often needed to control pain, symptoms, or to prevent further progression of disease.

This is our third hearing on coverage of outpatient drugs. The need for drug coverage including outpatient prescription drugs was first raised at a March 30 hearing on catastrophic illness expenses, and a full hearing was devoted to the issue on April 23.

A subcommittee markup of an amendment to add prescription drug coverage to H.R. 2470 is scheduled for Thursday. At the markup the subcommittee will consider a proposal requested by the House leadership on the majority side that I have developed in consultation with other members of the subcommittee. It is an outline to be used as a markup vehicle. That outline has been circulated to the witnesses for today's hearing.

Under the proposal, outpatient prescription drug costs would be covered, subject to a $500 annual deductible and a 20 percent coinsurance. A similar proposal has been developed by the gentleman from California, Mr. Waxman, of the Energy and Commerce Health Subcommittee.

It is estimated that the outlays will be approximately $760 million in 1989 and $1.3 billion in 1990, the first full year of implementation.

The benefit will be fully paid for by the elderly. Half of the cost under our proposal would be financed by $1.95 increase in the part B premium, and the remainder of the cost would be financed by a 10-percent increase in the income-related supplemental premium that has already been passed out of this subcommittee.

A variety of measures will be included to ensure the elderly's money is well spent.

Payments to pharmacies will be limited to the lower of actual charges or average wholesale price plus a dispensing fee. The use of low-cost generic drugs will be encouraged, and the Secretary will be authorized to develop a formulary to exclude selected high-cost drugs from reimbursement if there are safe and effective alternatives available at a lower cost.

There may be some concern that the subcommittee is moving too fast with this legislation. The Chair feels we are not.

Inclusion of prescription drugs in Medicare was one of the first issues considered after enactment of Medicare more than 22 years ago. A 1969 report by the then Department of Health, Education, and Welfare led to Senate passage of a prescription drug benefit in 1972.

While coverage of outpatient drugs is new to the Medicare program, we have more than 20 years of experience from 48 different Medicaid programs at the State level. We also are able to draw on the experience of private health benefit plans which provide prescription drug coverage.

We have already waited too long. This is the time to remedy a major shortcoming in the Medicare benefit.

We have moved beyond the question of whether drugs should be included in Medicare.

The purpose of today's hearing is to review specific reimbursement, administrative, and financing issues so the subcommittee can proceed to mark up this legislation.

[An outline of the proposal follows:]

## OUTLINE OF STARK PRESCRIPTION DRUG BILL—REVISED MAY 29, 1987

1. Coverage/Deductible: Covers all prescription drugs with a $500 annual deductible indexed by the increase in drug costs.

2. Cost Sharing: 20 percent coinsurance.

3. Payment for Brand Name Drugs: Payment would be based on the lower of: (i) actual charges or (ii) average wholesale price plus a $4.50 dispensing fee to be indexed starting in 1990 by an index reflecting changes in costs and productivity for retail pharmacies.

4. Special Payment Rules for Generic Drugs: Payment would be based on the lower of: (i) actual charges or (ii) 125 percent of average wholesale price of the lowest cost generic brand plus dispensing fee.

5. Formulary: The Secretary of Health and Human Services would be authorized to develop a formulary. The Secretary could exclude a high cost drug from the formulary if there are less expensive alternative drugs which are similar in terms of safety, effectiveness, and ease of administration. The Secretary would be required to establish a procedure for consultation with the FDA and NIH and appropriate medical experts. Medicare payment would be denied for nonformulary drugs unless prior authorization has been obtained.

6. Participation and Assignment: Participating pharmacies would be required to accept assignment on all claims. Reimbursement for drugs purchased at a nonparticipating pharmacy would be made on a non-assigned claims basis only, that is, the beneficiary would be required to pay the pharmacy and then submit a claim for reimbursement to Medicare.

7. Administration: Claims would be sent to the Medicare carrier only after the annual deductible is met. Participating pharmacies would be required to have electronic billing by 1991 except in rural areas. Medicare payment would be limited to no more than a 60 day supply of medications per prescription.

8. Financing: Fifty percent of the cost of the benefit would be financed by an increase in the monthly Medicare Part B premium. The remaining cost would be financed by an increase in the Medicare Supplemental Premium as set forth in H.R. 2470. The increase in the Medicare Part B premium and the supplemental premium would become effective on January 1, 1988.

Chairman **Stark**. I would suggest that it will become evident in the hearings and to the members of the committee as we move along that the only opposition to these proposals comes from the manufacturers of prescription drugs, motivated, I think, by greed and motivated by an urge to continue profits extracted from the poor elderly who are defenseless against obscene marketing practices. They will pull out all stops to defeat what is socially and morally right.

I just want to make it clear as we begin the hearings that the opposition to this program will come from those people, and I hope that we can call attention to this as they begin their march to withhold a benefit from the elderly, which they have managed to do all these years, and that at least the American public will know if there is no prescription benefit for those people who need it so badly, that it is, indeed, these same manufacturers who parade under the guise of free enterprise and patriotism that will cause it to be defeated.

I just wanted to set the tone for the hearing and make sure that you can all separate the good guys from the bad guys without T-shirts having to be handed out.

Mr. Gregg.

Mr. **Gregg**. Well, it is not my practice to make an opening statement, but in light of the chairman's representation of me and others who intend to oppose this legislation as being nothing more than tools of the big industry of drug manufacturers, I find it appropriate to make an opening statement.

I think the chairman's opening statement is the most irresponsible statement I have heard since I have been on this Subcommittee.

Chairman **Stark**. Stick around.

Mr. **Gregg**. I am sure, unfortunately, that we will hear further irresponsible statements.

But there are major questions of policy being raised here. Some of the questions would involve cost, such as how we protect the Medicare trust fund and whether we maintain the fiscal integrity of that trust fund.

Chairman **Stark**. If the gentleman will yield, this has nothing to do with the trust fund. It is not going to be paid for from the trust fund.

Mr. **Gregg**. I did not yield to the chairman. I would like to be able to make my opening statement.

Chairman **Stark**. Proceed.

Mr. **Gregg**. This has a great deal to do with the trust fund. It deals with the whole fiscal responsibility issue of whether we are going to have a viable Medicare program. And when we initiate a new program, whether we fund it out of the premiums or whether we fund it out of some other activity, inevitably if that program runs at a deficit, it is going to end up impacting the trust fund.

That happens to be my primary concern here. I do not really care whether the drug producers in this country make money or do not make money. What I am concerned about is whether we have a viable trust fund for the next generation, as well as this generation.

We are stepping off a precipice here, dealing with the cost of a program which we have absolutely no feeling for. In 2 days we are going to go from a period of hearings to a period of markup. The best figures we have appear to be 1977 figures. We are stepping off a precipice where we cannot only not see the bottom of the valley that we are going to fall into, there may be no bottom of the valley because of the fact that we do not know what type of usage is going to occur as a result of creating this additional benefit.

We do have some experience in States like New York and New Jersey where, when they instituted prescription programs for their Medicaid recipients, they found that their basic estimates were grossly understated, and in the end, they ended up with a tremendously expensive program.

I suspect a prescription program can be designed that will be effective and that will address the needs of the elderly in this country; and that it can be a program which can be a merger of private sector insurance activity with the public sector backup activity.

But I do not think moving on it in 2 days is a responsible way to proceed. It seems to me that if we are going to address this major new benefit which will, in the end, cost a minimum of a billion dollars a year and probably significantly more, we should give it much more time than just one day of hearing and one day of markup.

Chairman **Stark**. Anybody else care to make an opening statement?

[No response.]

Chairman **Stark**. We will then call our first panel to discuss the question of the need for the drug benefit. It will consist of Ms. Margaret Langston of the American Association of Retired Persons; Mr. Samuel Brightman of the National Council of Senior Citizens. We also have Michael Zimmerman, the Senior Associate Director of the Human Resources Division of the U.S. General Accounting Office for the next panel. We have three panels.

We will let Margaret Langston testify first, and start your testimony when you are comfortable. Thank you.

## STATEMENT OF MARGARET LANGSTON, AMERICAN ASSOCIATION OF RETIRED PERSONS, ACCOMPANIED BY PATRICIA SMITH, LEGISLATIVE REPRESENTATIVE

Ms. **Langston**. Good morning.

Over the past 5 years, I have suffered from a number of different ailments—asthma, diabetes, high blood pressure, a stroke, and bladder problems. Because of these ailments, I have had to use large amounts of prescription drugs. Currently, I am required by a doctor to take insulin and 12 other types of prescription drugs.

I cannot talk well because I had a stroke.

Chairman **Stark**. That is quite all right. You take your time.

Ms. LANGSTON. This medication which I must take costs me between $500 and $725 a month. Over the past 5 years, I have spent approximately $30,000 on these necessary drugs.

I am 66 years old and qualify for Medicare, but this does not cover any of the costs of my prescription drugs. Before retiring, I was a housekeeper and now get $182 a month from Social Security. Unfortunately, this does not go far in paying for my medication. I do not have any other health insurance. My husband and I live on a limited monthly income of about $900, but I am not eligible for any public assistance program which might cover the cost of prescription drugs. To pay the bills, my husband, who is also retired and in ill health, now takes part-time jobs to bring home extra money. Sometimes I even use my credit cards to buy my medication. That way I am able to get the medication I need right away, but can spread the payment out over a few months.

I do not have a choice about whether or not to buy prescription drugs. I have to use this medication in order to stay alive and well. Sometimes, I do not know what is going to happen. The high cost of this medication virtually eliminates all our monthly income. If these prescription drugs were covered by Medicare, my husband and I would have a decent amount of income to live on and would not have to worry about whether or not we could afford to pay for the drugs that I need to stay healthy.

Thank you.

[AARP submitted the following prepared statement:]

# STATEMENT OF THE
# AMERICAN ASSOCIATION OF RETIRED PERSONS
# FOR THE RECORD OF THE
# HOUSE WAYS AND MEANS HEALTH SUBCOMMITTEE
JUNE 2, 1987

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As a membership organization of 25 million Americans age 50 and older, AARP has always maintained a keen interest in pharmaceutical issues. Older Americans consume a disproportionately high amount of prescription drugs and are less well protected in this area than younger members of the population. In the U.S., persons aged 65 and older represent only 12 percent of the population, but they consume 30 percent of the prescription drugs. And, while three-fourths of all adults aged 19 to 64 have insurance coverage for outpatient prescriptions, only 41 percent of Americans over the age of 65 have such protection. The high costs of drugs and the failure of the private sector to offer solutions emphasize the need for legislation to protect older Americans.

AARP is recommending a Medicare prescription drug benefit that would provide meaningful coverage for beneficiaries who are faced with catastrophic prescription drug costs. This benefit would include at a minimum:

- A $500 deductible and a 20% coinsurance payment.
- Continuation of Medicare's existing prescription drug benefits;
- Medicaid coverage of individuals up to 100 percent of the federal poverty level, in the same way that this coverage for deductibles, coinsurance and premiums is included in the Stark-Gradison plan.
- Further, AARP recommends that beneficiary coinsurance payments be counted toward a $1000 catastrophic cap on Part B expenses.

Little data exist on the potential utilization of a full Medicare prescription drug benefit, its costs, or its administration. AARP recognizes the seriousness of these considerations and, therefore is proposing a benefit that is fiscally responsible, administratively manageable, a source of useful data, and most importantly, a benefit of real value. A more detailed description of the Association's prescription drug proposal is included in the testimony presented to the Subcommittee and included in the hearing record on April 23, 1987.

AARP hopes that 1987 will be the year of meaningful catastrophic coverage for older Americans. We recognize that after this year we will still have far to go in protecting the nation against some of the most burdensome health care costs. But in the area of prescription drugs, we can take steps this year to provide a benefit that is fiscally sound and administratively manageable. We urge the members of this committee not to pass up this opportunity.

Chairman STARK. Thank you, Ms. Langston, very much.

Mr. Brightman, you have a prepared statement which we will put into the record as you submitted it to us. Please feel free to outline it or expand on it or address us in any way you are comfortable.

## STATEMENT OF SAMUEL C. BRIGHTMAN, SENIOR REPRESENTATIVE, NATIONAL COUNCIL OF SENIOR CITIZENS, ACCOMPANIED BY ERIC SHULMAN, DIRECTOR, LEGISLATIVE LIAISON AND RESEARCH DEPARTMENT

Mr. BRIGHTMAN. Thank you. My name is Samuel C. Brightman. I want to thank the committee for giving me this brief moment with a captive audience to talk about my ailments and my medications. Many seniors would give a month's Social Security for this opportunity.

I am here to speak for myself and also for the National Council of Senior Citizens, and you have their position in some detail. I want to try to give you an idea, as my colleague here has done, of what the costs of drugs means to individual seniors.

I am 76 years old. My prescription bill runs between $1,500 and $2,000 a year. I have no pension. I draw Social Security. My wife and I are both fortunate enough to be able to work and augment our income, so I suppose we enjoy a middle-class life style. We own a modest home in a modest neighborhood in conjunction with Riggs Bank.

Some years ago, after I had a cardiopulmonary arrest, we found it necessary to take out a home equity loan. So instead of our owning more of the house and Riggs less, it is moving in the other direction. But my doctor assures me I will be gone before we lose the whole house to Riggs. That is the good news. [Laughter.]

Some days I take about 40 doses of various medication, but basically I have a regular regimen of drugs that I must take in order to stay alive and function. I have had COPD. So many of us seniors have chronic bronchitis and emphysema that the doctors have to have an abbreviation for chronic obstructive pulmonary disease.

I have had that for some time. That is fairly expensive medication. In 1983, I suffered a cardiopulmonary arrest. When I came to in the Sibley intensive care with things stuck in every orifice but one and feeling very uncertain, the first thing I asked the doctor was: What happened? I still remember the elegant language. He said, "You had a cardiac event."

Since the cardiac event, I take Cardizen, Isordil, Lanoxin, and I carry nitroglycerin tablets. For the lung condition, I take Theo-Dur three times a day. I use two kinds of broncho-dilator inhalers.

I have developed some gastric problems, and I take Zantac, which is a very expensive anti-ulcer drug. I have high blood pressure. I am not sure whether it is cause or effect. In any event, I take Maxzide, which is another expensive drug.

I take some medicine for an eye condition. I am starting to grow cataracts and I have a growth on the retina of my left eye which requires both medication and observation.

I have a list of some approximate prices. As I say, my life literally revolves around drugs.

I would like to point out that this may seem like a remarkable list of ailments. It is not. People my age can get together and bore each other to death describing all the things that are wrong with us and the medicine we take. I am one of the fortunate people who is able, maybe, to make light of it, although I have to say that the bills are not a joke. They are a serious problem to us.

I had to give up dealing with my neighborhood pharmacy. I liked the people there. I believe in neighborhood drug stores. I had to go to a chain because they have bigger purchasing power, and they can sell medicines to me at less than my neighborhood pharmacist. I have seen the invoices they can purchase it for.

As I say, I do try to do those things. There is one bit of irony in my case, and that is that the lung disease prevents an operation, open-heart surgery on me, which I could get covered. But the medication which has kept me going now for several years and been reasonably effective is not covered. For many people, that is a far more serious discrepancy than it is for me.

These are why I hope that Medicare will be made truly effective by the inclusion of some kind of a program to cover the cost of prescription drugs. I hope that the deductible will be low enough so that it will serve not just people in my circumstances, but will serve you and will be of real help to you, Madam.

You have the detailed things, and I would be very happy to answer any questions. Thank you again.

[The statement of Mr. Brightman follows:]

Statement Presented to the

Subcommittee on Health of the
House Ways and Means Committee

on the

Issue of Prescription Drug Coverage Under Medicare

By

Samuel C. Brightman
Senior Representative

accompanied by

Eric Shulman
Director, Legislative Liaison and Research Department

National Council of Senior Citizens
925 15th Street, N.W.
Washington, D.C. 20005

June 2, 1987

Thank you, Mr. Chairman, for giving me this opportunity to testify this morning. My name is Samuel Brightman and I am here in a dual role--first to show you how prescription drug costs can affect a senior citizen, and, second, as a representative of the National Council of Senior Citizens.

I am 76 years old and am required to take an average of $2,000 worth of prescription drugs each year. Some days, I take close to 40 doses of drugs a day--all under prescription and most for life-sustaining treatment.

In 1983, I suffered a cardio-pulmonary arrest. To care for my heart, I have to take Cardizem four times a day, Isordil four times a day, Lanoxin once a day, and I carry a supply of nitroglycerin tablets.

I have had chronic obstructive plumonary disease (COPD) resulting from emphysema and chronic bronchitis for more than ten years. For this condition, I take Theo-Dur three times a day, and I use a bronco dialator inhalator four times a day.

I have developed gastric problems as a result of my emphysema. In order to care for these problems, I have to take Tagamet or Zantac, which are anti-ulcer drugs, twice a day, and Phazyme 95, four times a day.

I have high blood pressure and have to take Maxzide once a day. I also have various skin problems for which I am required to use a prescription shampoo, take steroids, and use a prescription ointment for any skin cancers that develop.

I have chronic gland and duct problems that cause my eyes, nose, and throat to become very dry. I have to use saline solutions to keep this condition under control.

From time to time, I am also prescribed tranquilizers and I take over-the-counter arthritis medication.

The approximate cost of each of these medications is provided for you in the following table.

| Drug | Cost (approx.) |
|---|---|
| Cardizem | $43/100 tablets |
| Isordil | $9/100 tablets |
| Lanoxin | $4.50/100 tablets |
| Teo-Dur | $25/100 tablets |
| Inhalators (2) | $30.00 |
| Nitroglycerin tablets | $2.75/100 tablets |
| Zantac | $97/100 tablets |
| Shampoo | $8.00/tube |
| Artificial tears & saliva | $15/bottle |
| Steroids | $5 |
| Skin Cream | $7.50/tube |
| Tranquilizer (Xanax) | $35/100 tablets |
| Arthritis OTC | $6/100 tablets |
| Maxzide | $32/100 tablets |

My daily routine revolves around these drugs. In the morning before breakfast, I use my inhalator, I take about eight different drugs, and I use artificial tears and artificial saliva and a saline solution for my nose.

At midday, I take about five drugs, more if necessary depending on what conditions may be acting up. At dinner, I take another six drugs, and at bedtime, another eight.

There are a few points that I would like to especially highlight:

1) My conditions are the common health problems that affect many people my age. They are not necessarily the conditions people would put on a list if they were to try to guess which health conditions cause people to have very large drug expenses. But because of the severity and combinations of my conditions, my prescription drug expenses are definitely "catastrophic."

2) I have taken many steps to keep these costs as low as possible. I have been very careful to substitute lower cost generic drugs wherever I can. I also switched from my neighborhood pharmacy, which I liked a lot, to buying my drugs at a chain pharmacy, since I get a discount there. But even with these efforts to keep my costs low, it still adds up.

3) My pulmonary diseases prevent heart surgery. It's ironic that Medicare would pay for the costly surgery, if I could endure it, but won't pay for my drugs, which are less expensive.

4) I don't like taking all these drugs, but I really don't have any choice. Most of them are necessary for me to live. If I were to let some go, my conditions would only get much worse and require more intensive treatment.

I sincerely hope that this Committee will vote to include prescription drug coverage into the catastrophic health care bill. Without it, the bill doesn't do much for many seniors in my opinion. With it, the bill would be of real value in meeting the terribly high health care costs that seniors are having to pay alone.

Attached are specific comments about the provisions included in the prescription drug bill that you have proposed. Thank you for your consideration of these points.

NCSC Comments on the Proposed Prescription Drug Bill

NCSC commends the Chairman for his leadership and his commitment to this issue. On the whole, we are very supportive of the proposal before us, although, we urge specific changes outlined below, the most important of which is a lower deductible.

1) Coverage and Deductible

The proposal would cover all prescription drugs after a $500 annual deductible, indexed to the increase in drug costs.

NCSC is very supportive of coverage of all drugs, rather than selected drugs or certain conditions. Mr. Brightman's case clearly shows the difficulties inherent in trying to judge which conditions are worthy of prescription drug coverage. Instead, the suggested approach is much sounder.

However, NCSC urges the Committee to consider a significantly lower deductible and indexing the deductible to the increase in the cost of living.

As coverage issues surrounding catastrophic illnesses are discussed, the question often revolves around what is considered "catastrophic." Basically, a health care problem becomes "catastrophic" when the financial strain of caring for that condition becomes great. In this way, a problem can be "catastrophic" at any dollar level, depending on one's income. The average senior citizen spends an estimated $314 a year on prescription drugs. For many seniors, especially those with low incomes, this out-of-pocket expenditure is nothing short of catastrophic. NCSC advocates a $200-$300 deductible for prescription drugs. Including benefits in the package doesn't mean anything at all unless people are able to use them.

Further, we urge the Committee to tie the deductible to the increase in the cost of living. In other parts of the catastrophic health care bill, the hospital deductible was indexed to the COLA, providing a welcome relief for seniors. In tying the drug deductible to the drug inflation rate, seniors on fixed incomes will have to spend greater proportions of their income on the deductible. Seniors' spending requirements under the drug benefit should be tied to their ability to spend.

2) Cost Sharing

The proposal would have seniors pay a 20 percent co-insurance for each prescription filled. NCSC supports the idea of using a percentage co-payment rather than a straight-dollar figure per prescription filled. It seems unfair to require the same dollar co-payment for each prescription regardless of the cost of the drug.

3) Use of Generics and Proprietary Drugs

NCSC also supports provisions in the proposal which encourage use of safe and effective generic drugs as substitutes for brand-name drugs. In our opinion, reliance on generics can be one of the most aggressive cost saving devices in the legislation.

4) Formulary

NCSC fully supports the use of a formulary in a prescription drug benefit. A formulary is a list of drugs that have been found safe and effective in the treatment of specific medical conditions. Formularies help ensure against use of inappropriate medications, help educate physicians about less effective drugs, and help ensure greater uniformity in prescribing practices. Many leading hospitals have used formularies for years with success and with high degrees of physician acceptance. NCSC also believes that an exception clause should be in place so that physicians could prescribe drugs not in the formulary in cases where a patient's specific medical condition would require it.

5) Participation and Assignment

NCSC wholeheartedly supports the creation of participating pharmacies that would be required to accept assignment on Medicare claims. We think this is a workable, sensible approach to administration of the benefit and provides absolutely essential protections for Medicare beneficiaries.

6) Administration

The proposal would limit payment for drugs to no more than a 60-day supply of medications per prescription. NCSC questions the need for and the benefits of this proposal, especially for beneficiaries with chronic drug needs. For the most part, the only seniors who would benefit from a drug benefit with a $500 deductible are those with chronic drug needs, like diabetics. Most of these patients have taken drugs for years and have drug requirements that don't change. Many of these patients purchase drugs in bulk for convenience and economy. Prohibiting these patients from buying more than a 60-day supply of medication seems unnecessary and unduly restrictive.

7) Financing

The proposal splits financing for the drug benefit: 50 percent from the flat premium and 50 percent from the supplemental premium. NCSC would prefer to see the benefit financed through including state and local workers under Medicare. CBO estimates revenues from inclusion of approximately $2 billion each year throughout the five-year costing period. This would provide significant resources to pay for the drug benefit and would close a very inequitable gap in our coverage laws.

As a second choice, we advocate financing the prescription drug benefit wholly through the supplemental premium. In this way, people with higher incomes would be required to pay more for the same level of protection. Using the supplemental premium would also keep the flat premium low, allowing states to buy-in low income seniors at higher levels of the Federal poverty line--a very important aspect of the legislation.

As a third and fall back choice, we will accept dividing the financing between the supplemental and the flat premiums. At the very least, this method would keep the flat premium somewhat low in order to allow low-income seniors to afford the benefit and to allow states to buy-in the poor, albeit at necessarily lower levels.

Chairman STARK. Thank you very much, Mr. Brightman. Let me ask you this. You are aware that if we add some prescription drug benefit to Medicare you are going to end up paying something for it, are you not?

Mr. BRIGHTMAN. Yes.

Chairman STARK. You have heard about the different proposals. There are basically two ways to pay. There is a flat monthly part B premium, or a part B premium and an additional premium related to your income.

Let's start with a $500 deductible. Under our proposal let us just assume for a minute you would have to pay an additional $4 a month. So you would be paying $4 a month more, and you would have to pay the first $500. After that $500, Medicare would pick up your drug expense, and you would still have to pay the $4.

Mr. BRIGHTMAN. Yes.

Chairman STARK. Now, would that sound like a good deal, and would that be helpful to you?

Mr. BRIGHTMAN. Yes. Yes, it would be helpful. In my case, it would be a distinct improvement, and assuming I continue to have the same income, it would not be a hardship.

I suspect that there are an awful lot of people served by Medicare for whom that would be a hardship. I have to say I cannot understand how people live at the poverty level, and there are a lot of elderly around that level in retirement who lived a different level above. And I am concerned that some of that would be a hardship on them.

In my own case, it would not be.

Chairman STARK. Let me assume for a minute, as has been indicated this morning, that not only the Chair but the GAO and 40-odd States do not know what they are talking about—a safe assumption. Assume that we are underestimating the cost of this program by double, and you have to pay $8 a month. Would it still seem to you to be a fair program?

Mr. BRIGHTMAN. Yes. It would be for me. I have to tell you, my wife and I are both fortunate enough to be working. We have no savings and we have no pension benefits, but it has only been a few years where we have not paid more in taxes than we have gotten in benefits.

We are not going to be comfortable with the increases. I am not comfortable with the fact of the change including some of the Social Security, because I do not have that kind of an income. But I think that the elderly who can afford to pay something would be almost proud to do it. I would certainly feel that—all the elderly I know who could pay more would be glad to help a person in her circumstances, for example.

I would like the committee to remember that a lot of the elderly are helping to pay for the cost of government, and we are not always just a burden. We are citizens, and we participate with the IRS as well as vote.

Chairman STARK. Thank you.

Ms. Langston, do you and your husband purchase medigap insurance or extra insurance beyond your part B Medicare?

Ms. LANGSTON. No.

Chairman STARK. Okay. If you had to pay $2 a month, and I say that you do not have to pay that because of your income that you have explained in your statement. But let us say we had to double that, if the program were twice as expensive as we think it might be. If you had to pay $4 a month, you and your husband each—so that would be $8 a month for both of you—and then you would still have to buy the first $500 of drugs. That would be about $40 a month if you paid for them each month. But Medicare would pay everything after you reached $500. Would that seem like it was worth it to you to pay the $4 a month for yourself and $4 a month for your husband?

Ms. LANGSTON. I pay $18 a month now.

Chairman STARK. How much a month?

Ms. LANGSTON. $18 a month.

Chairman STARK. I know that. You would have to keep paying that. It would go up $4 more. Would that be worth the extra $4 to you if all the drugs over $500 were paid for?

Ms. LANGSTON. I think it would.

Ms. SMITH. I think, Mr. Chairman, that there is an important point here to take note of; and that is, that Ms. Langston said she is paying over $500 a month not a year.

Chairman STARK. Oh, she is paying over $500 a month for drugs.

Ms. SMITH. Yes.

Ms. LANGSTON. I pay from $500 to $700 a month.

Chairman STARK. I think I missed that. So very clearly, after the first month, Ms. Langston, you would only have to keep paying $4 a month if we doubled it, and Medicare would pay the balance. That would be, I think, advantageous.

Mr. Gregg.

[No response.]

Chairman STARK. Mr. Moody.

Mr. MOODY. I would like to ask the gentleman this. Do you feel other senior citizens who would not be perhaps as needy of these drugs at this time as you yourself are, do you feel they would object to being charged $4 or eventually maybe $8 a month, even though they do not at the current time need the drugs to the extent that you do?

Mr. BRIGHTMAN. Well, I know some place where that gets pretty marginal for people who have a hard time covering their Medigap insurance. I think there are a lot of persons in more favorable circumstances who share my feeling that they would not object to that, particularly if they felt it was the only way to get less fortunate people the help that they very desperately need.

As a matter of principle, I would like to keep the deductible as low as possible, and the added burden for the part B as low as possible. I should say I am not speaking for the council now.

Personally, I fully expect that if something of this nature goes through, people in what I would suppose you would call middle class or the lower middle class are going to pay a good deal more. I will benefit even at the higher level because I have such high drug expenses, but other people I know in roughly similar circumstances that do not have high drug expenses would be paying extra for something that at this time does not benefit them. I do not know any of them who feel that if it was the choice of $8 a month versus not adding coverage who would not go the same way I do and say, yes, we will accept it. We want you to think about the others.

The $500 a month bill that she pays, I just think that is a horrible, horrible thing to think about. And if I pay $8 or $16, as long as I am able to, to prevent a hardship like this, I will do it and so will the rest of the senior population, sir.

Mr. MOODY. The $8 you just pulled out of the air. I do not know what the premium would have to go to eventually. Certainly $4 premiums would probably happen fairly soon.

I wonder if you think there would be much agitation from other seniors to fight politically to have that number reduced, even though it meant then adding the cost to the general taxpayer.

Mr. BRIGHTMAN. I do not know, and I do not presume to speak for the council on that.

I think overall the senior population, if the case were presented convincingly and that was the only way to get the prescription drugs covered, I think an awful lot of us would support any kind of a proposal that will bring that about.

There gets, as you must be aware, a point where it would get so high that it would not really be any improvement on the present condition. But I do not think we are rigid, and I think a good many senior citizens, as I am, are very sensitive to this stereotype that is coming around that we are a bunch of lay-abouts enjoying the national deficit, and the only problem we have is whether I will take the Porsche to the golf course or Mother will take it to Neiman-Marcus.

We will pay our share.

Mr. SHULMAN. Congressman, let me just add that it seems to us that there are a couple of other options here in terms of financing. One, of course, is not to rely wholly on the flat premium, but to put part or perhaps even all of the financing burden in the supplemental premium, which is more progressive; something that I think more people could afford to pay.

The other option which I guess is not being discussed at this subcommittee, but I think is still a viable option, something that people need to look at, is coverage of State and local employees under Medicare. That is something that should happen in any case, and it seems to me that part or all of that money could and should be used to offset some of the costs of the prescription drug program, at least in the short term.

Mr. MOODY. Just a final question to the gentleman. Assuming that this is a self-funded program so it will not add to the deficit and it will not add to other parts of Government spending, there is going to be a tradeoff between a higher deductible and higher premiums, whether they are flat or progressive. So the higher we make the deductible, the lower the premiums can be and vice-versa.

Similarly, with the copayment. The numbers we are looking at would have a $500 front-end deductible, which you would have to assume yourself, and then you would be helped. Then 80 percent cost pickup on the drugs, so a 20-percent coinsurance, in effect.

If we were to try to hold the cost down so we could hold the premiums down, would you personally prefer to see that $500 go up a little bit so that it would relieve the cost of the premium? Or would you like to see the coinsurance, the 80-20 ratio go up a little bit, so maybe it is, let us say, 50-50 or 40-60? Which of either of those two would you think might be a way to go, if we had to, to hold the cost down?

Mr. BRIGHTMAN. I would be inclined towards trying to hold the line on the deductible. I can see people with a very real need who might not make it to the deductible.

Mr. MOODY. So you would like to hold firm on the $500 and not let that creep upward.

Mr. BRIGHTMAN. I would hope it could be lower than that, sir.

Mr. MOODY. All right. Thank you very much.

Chairman STARK. Mr. Gradison.

Mr. GRADISON. No questions.

Chairman STARK. Mr. Donnelly.

Mr. DONNELLY. I just have two questions for each organization. No. 1, do you support mandatory assignment for pharmacists under this legislation; that is, no balance billing? I want the organization's position.

Ms. SMITH. Participating physicians would be required to comply with the mandatory assignment. Yes, that is how we see it.

Mr. DONNELLY. Pharmacists.

Ms. SMITH. I am sorry. Pharmacies, yes.

Mr. DONNELLY. So you support mandatory assignment for participating pharmacists.

Ms. SMITH. Yes.

Mr. DONNELLY. The second question is: Do you support income-relating the premium to pay for this program?

Ms. SMITH. Do you mean by that as a component of the supplemental premium that is currently looked at?

Mr. DONNELLY. Yes.

Ms. SMITH. That would be a possibility, yes, as the committee's current proposal of a 50-50 split between the basic and the supplemental.

We have not had a chance to analyze what those numbers might do to both the high and the low ends of both of those premiums, the basic and the supplemental. I think one of the things that we are getting to from a financing perspective is something of a bogus issue on the payment side in that the elderly are currently paying. And so the way in which they pay, if it is more predictable, it is certainly more acceptable to the senior population.

From that perspective, an analysis of what those two premiums would look like at both the high and the low ends would be essential, and I do not think any of us has seen that at this point. But when we see it, we will——

Mr. DONNELLY. But you support the concept of income-relating premium to people's ability to pay.

Ms. SMITH. The concept, yes, we do support.

Mr. DONNELLY. How about your organization?

Mr. BRIGHTMAN. Of course.

Mr. DONNELLY. You do?

Mr. BRIGHTMAN. Yes.

Mr. DONNELLY. Thank you.

Chairman STARK. Mr. Levin.

Mr. LEVIN. No questions.

Chairman **Stark**. Mr. Anthony.

Mr. **Anthony**. I would like to follow up on Mr. Donnelly's question about mandatory assignment. If both associations agree that mandatory assignment should be a component part of prescription drugs, would you also say that the committee should revisit mandatory assignment for other components of Medicare?

Mr. **Shulman**. The answer to your question, sir, is yes. We really do believe that the mandatory assignment issue is becoming more and more problematic in a number of States. And certainly in terms of our organization, many of our people around the country who are not seeing action on the issue at the Federal level are moving at the State level to try and deal with the mandatory assignment problem.

So we would support a good, hard look at the issue at the Federal level and legislation to impose mandatory assignment.

Ms. **Smith**. AARP is an active participant in the Physician's Payment Reform Commission, and we will continue to play out that role. At the completion of that Commission's work, we do believe that mandatory assignment is the direction in which the country ought to move.

Mr. **Anthony**. I want to ask both of you more of a strategic question. I think all of the members of the committee feel that within the realm of what is possible and what is do-able, we would like to cover prescription drugs. We would also like to cover long-term health care costs. We would like to have the deductible as low as possible. We would like to have the coinsurance as low as possible, we would also like to have the premium as low as possible, and we would like to have the cost as low as possible.

This issue does not come to us without some controversy. When we first entered into a discussion on catastrophic health, the administration, No. 1, shocked a lot of people in Congress by the fact that they came with a package and endorsed a package—a limited package with a premium, flat across the board. Our subcommittee modified that, and our full committee accepted a modification further to keep it on a premium and a supplemental premium—but only for catastrophic.

My question is: In terms of legislative strategy, would we be wise to go ahead and move forward on both prescription drugs and/or long-term care, nursing home care this year, or would we be better off to try to put together some type of congressionally mandated study that could pull together all of the reports, all of the studies, really take a hard look at the various options, and proceed on a more rational basis, rather than being pushed into adding prescription drugs as a forced afterthought to catastrophic.

I was curious as to what you think strategically, and what would happen if we postponed it for 1 year to try to pull all the data together.

Mr. **Shulman**. The only thing I would say in response is that when the President introduced the legislation, he called it the last measure of security for the elderly. I think there is a real perception out there that this catastrophic benefit is going to help far more people that we all know it actually will help.

We feel that the prescription drug issue is not a new issue. There have been countless hearings by countless committees over the last several years on this question. I do not see any logical reason for delaying something that needs to be done that would be broadly popular among the elderly, and that I think we have most of the data that we need to proceed.

Mr. DONNELLY. Would the gentleman yield on this point?

Mr. ANTHONY. Yes. I yield to my friend, Mr. Donnelly.

Mr. DONNELLY. I think the gentleman brings up a valid point.

Let me ask each organization: What is more important to you? A $500 deductible for this sort of coverage or a comprehensive long-term care benefit included under Medicare?

Mr. BRIGHTMAN. Do you want me to handle that personally, or do you want me to speak to——

Mr. DONNELLY. No, what is it? Because we have to make those decisions. I made a decision on long-term care about 2 weeks, much to my chagrin, that we were going to set that issue aside. Now, here we are 2 weeks later bringing up the issue of prescription drug coverage, and I would like to know where you people are coming from.

Tell me. What is more important?

Mr. SHULMAN. In a sense, we are talking, I think, to some extent about apples and oranges here. I mean, when you are talking about comprehensive long-term care reform, I think we are talking in the $15 to $20 billion financing range at a minimum.

Mr. DONNELLY. Well, that is not true, but go ahead.

Mr. SHULMAN. Well, it seems to me that we are at least cognizant of the limitations that we have on Federal resources at the moment due to the Federal deficit. We are trying to be responsible and yet pursuing an avenue of improving the bill in a way that would be broadly popular. Certainly, we would like to see long-term care reform, comprehensive long-term care reform. And if Congress is willing to——

Mr. DONNELLY. There is no such thing as long-term care reform. We have extremely limited long-term care under the Medicare program. That is the only program that this committee has jurisdiction over.

What is the answer to the question?

Mr. SHULMAN. Again, it is just hard. If you are talking about a program to fully cover long-term care services for all of the elderly as compared to a $500 deductible prescription drug benefit, then the answer is we would rather have the long-term care reform.

Mr. DONNELLY. Thank you. I am not trying to be mean to you. I am just saying what I am trying to put you through is the same process that we go through.

Mr. BRIGHTMAN. I want to answer that.

Mr. DONNELLY. It is not my time. Let me just yield back. But I wanted to make that point.

Mr. ANTHONY. I yield for you to answer that question.

Mr. BRIGHTMAN. Well, I just wanted to say, as an individual, he gives the right answer, but my personal comfort would be if we do something to help persons in her circumstance for that reason. Looking at the immediate problems of people who are hurting now, I would like to get the prescription drug program and come back to fight another day on the other issue. That is my personal feeling.

Mr. ANTHONY. Would you like to respond to the original question strategically? The reason I yielded to Mr. Donnelly is because strategically that has got to be part of the debate. In my mind, if we go to prescription drugs, we have pushed back the day that we will consider reform for long-term care because there are just so many premium dollars in the elderly pocket that can pay for all these extended benefits.

It is an important question that, I can tell you, it may not be part of the public record, but I can tell you it is something that is being debated behind the scenes every single hour that this bill is going forward, as everybody in this room knows.

Ms. SMITH. It has been an important discussion for AARP as well. I would have to agree with Mr. Shulman's assessment, and it is true of AARP, that long-term care is absolutely one of their highest priorities.

In the context of this year's debate, we made a strategic decision to opt for prescription drugs based on concerns about the deficit, our commitment to tax reform that we expressed in previous years, and an awareness that what we wanted to build this year was a program that could, in fact, be deficit neutral, and leave for a future time an extensive debate on programs of long-term care about which we know substantially less and also about which we know we will have to go to much greater lengths to raise the money to pay for them.

Mr. ANTHONY. Thank you, Mr. Chairman, and I yield.

Chairman STARK. Anybody else wish to inquire at this point?

[No response.]

Chairman STARK. If not, I would thank the panel very much and call Mr. Zimmerman from the GAO, Senior Associate Director of the Human Resources Division. We look forward to your testimony. Your prepared formal statement will be inserted in the record in its entirety without objection, and I will let you proceed in any manner that you would like.

Welcome back to the committee.

## STATEMENT OF MICHAEL ZIMMERMAN, SENIOR ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY THOMAS DOWDAL

Mr. ZIMMERMAN. Thank you very much, Mr. Chairman. Let me begin first by introducing Mr. Dowdal who is with me today. Mr. Dowdal has had a lot of experience in financing programs, and he has a vast amount of knowledge about this issue.

We are pleased to be here today to discuss issues related to the establishment of outpatient prescription drug coverage under Medicare. You asked that we discuss our experiences in reviewing the prescription drug benefit under Medicaid, and how the lessons of that work could be applied to Medicare.

You also asked that we specifically address fraud control and raise other issues that we believe the subcommittee should consider in designing a Medicare benefit.

We believe that Medicaid's experience with its prescription drug program provides a good base for designing a program for Medicare. While the Medicare program itself has virtually no experience with financing outpatient drugs, many of its carriers have under their commercial lines of business. Moreover, HCFA, which administers Medicare, has had substantial experience with financing outpatient drugs through its involvement with the Medicaid program.

For these reasons we do not see a lack of experience as being a major hurdle to establishing prescription drug coverage under Medicare.

Our Medicaid work has shown that determining a reasonable price to pay for drugs can be a problem. Most States pay for drugs at the lower of charges to the general public or the pharmacists' cost of the drug plus a dispensing fee. The first limit—charges to the general public—is designed to assure that Medicaid does not pay more for a drug than someone who walked into the drugstore would. This method also simplifies billing for the drug because the pharmacy merely includes its usual charge for the drug on the Medicaid claim and does not have to maintain a separate special charge list for Medicaid. For these reasons, we would support the "charges to the general public" limit for any Medicare program that might be enacted.

We also believe that the second payment limit—cost of drug plus a dispensing fee—is a valid check on the reasonableness of pharmacy charges. In effect, Medicaid tries to estimate what the pharmacist paid for the dispensed drug, adds a dispensing fee to compensate the pharmacy for its costs, and to pay it a reasonable profit, and compares the resulting amount to the billed charges, paying the lower of charges or estimated costs plus profit.

However, Medicaid has had problems in estimating the costs of dispensed drugs. Historically, states have tended to use average wholesale prices as listed in several compendiums. HCFA and HHS's IG have stated that these average wholesale prices exceed pharmacies' actual costs by an average of 15 to 18 percent. On the other hand, over the years there have been complaints by pharmacies and their associations that particular States' dispensing fees are unreasonably low. While we have not specifically assessed the validity of these claims, a well-designed survey of pharmacy costs should enable Medicare to set a reasonable dispensing fee if a drug program is enacted.

In the final analysis, the question of how much to pay for a drug comes down to the degree of assurance desired that the pharmacy is not overcompensated and that the program does not pay for expensive brand name drugs when therapeutically equivalent generics are available. The better the estimate of what the pharmacy pays for a drug, the more assurance the pharmacy is not overpaid. And the more incentives to dispense lower cost drugs or only paying the price of lower cost drugs, the more assurance that high price drugs are not paid for when equivalent, lower cost ones are available.

Turning now to fraud and abuse, the primary problems in the Medicaid drug program include charging for brand name drugs when lower priced generic drugs were dispensed, and billing for services not rendered.

Current Federal and State recordkeeping requirements, along with severe criminal and civil penalties for defrauding or abusing

Medicare, should act as strong deterrents to fraud and abuse. In addition, the recordkeeping requirements make it relatively easy to investigate cases of suspected fraud. Combining these factors with an adequate amount of auditing and investigative effort to give meaning to the deterrent built into law, fraud and abuse by pharmacies could be controlled.

I would like now to briefly outline the other issues presented in my prepared statement that we believe the subcommittee should consider if it decides to design a Medicare prescription drug program.

First, about 11 percent of Medicare beneficiaries are also eligible for Medicaid, and Medicaid usually covers their prescription drug needs. If a Medicare drug program were primary to the Medicaid one, State Medicaid costs would decrease and Medicare costs increase.

Second, if Medicare allowable costs are used to determine when a beneficiary has met the drug deductible, beneficiaries will not know when they have reached the deductible. On the other hand, if beneficiaries' actual cost is used, it could somewhat decrease their incentive to shop for low priced drugs.

Third, laws permitting pharmacists to substitute therapeutically equivalent lower priced drugs for high priced ones vary among the States. In some States, pharmacies could face the problem of not being able to substitute but have their payment limited to the lower cost drug.

A key issue is whether pharmacies should be required to accept assignment as a condition of participation. If not, beneficiaries will not be assured their costs would be limited to any deductible or coinsurance amounts. If assignment is mandatory, some pharmacies might refuse to participate. However, there are indications that mandatory assignment would probably not affect participation to a large extent.

Finally, for ease of administration, we believe the subcommittee should consider using a copayment rather than coinsurance. With a copayment, everyone knows up front what the beneficiary liability is. This concludes my statement, Mr. Chairman.

[The statement of Mr. Zimmerman follows:]

Statement of
Michael Zimmerman, Senior
Associate Director
Human Resources Division

I am pleased to be here today to discuss issues related to the establishment of outpatient prescription drug coverage under Medicare. You asked that I discuss what we have learned in reviewing the prescription drug benefit under Medicaid and how those lessons could be applied to Medicare. You also asked that we specifically address fraud control and raise any issues that we believed the Subcommittee should consider in designing a Medicare drug benefit.

We believe that Medicaid's experience under its prescription drug program provides a good base of information for designing a program for Medicare. Medicaid has experienced some fraud and abuse in its drug program. Current Medicare law provides substantial penalties for fraud and abuse, and state pharmacy laws and Medicare law require record keeping that provides the evidence necessary to prosecute fraud and abuse. We believe that the deterrent effects built into the current law, combined with adequate review and audit of claims and enforcement action, should enable fraud and abuse to be controlled.

## DOES HCFA HAVE EXPERIENCE WITH FINANCING OUTPATIENT DRUGS?

Because Medicare currently does not cover outpatient prescription drugs that can be self-administered, except for the recently enacted coverage of immunosuppressant drugs, the program has virtually no experience with financing outpatient drugs. However, many of the carriers that process other types of Medicare outpatient claims generally do have experience with paying for prescription drugs under their commercial lines of business. Moreover, the Health Care Financing Administration (HCFA), which administers Medicare, has had substantial experience with financing outpatient drugs through the Medicaid program. All but two of the states have elected to cover prescription drugs under Medicaid. HCFA has established guidelines and procedures for the states to use in administering prescription drug programs and has helped states develop computerized management information systems to pay claims for drugs and manage the drug program.

Because of HCFA's and the carriers' experience with administering outpatient prescription drug programs, we do not see a lack of experience as being a major hurdle to establishing prescription drug coverage under part B of Medicare. Of course, HCFA and the carriers would need some time to institute the computer programs and other operational changes necessary to process claims.

## HOW CAN REASONABLE PRICES FOR PRESCRIPTION DRUGS BE DETERMINED?

Our past work on the Medicaid prescription drug program has shown that determining a reasonable price for drugs can be difficult. Most states pay for drugs at the lower of charges to the general public or the pharmacists' cost of the drug plus a dispensing fee. The first limit--charges to the general public--is designed to assure that Medicaid does not pay more for a drug than someone walking into a drugstore would. The program also simplifies billing for the drugs because the pharmacy merely includes its usual charge for the drug on the Medicaid claim and does not have to maintain a special charge list for Medicaid. For these reasons, we would support the "charges to the general public" limit for any Medicare program that might be enacted.

We also believe that the second payment limit--cost of drug plus a dispensing fee--is a valid check on the reasonableness of pharmacy charges. However, problems can arise in determining the amount at which to set the limit. In effect, Medicaid tries to estimate what the pharmacist paid for the dispensed drugs, adds a dispensing fee to compensate the pharmacy for its costs (building, utilities, labor, etc.) and to pay it a reasonable profit, and compares the resulting amount to the billed charges, paying the lower of charges or estimated costs plus profit.

States are supposed to set their dispensing fees based on surveys of pharmacy costs or similar data. Over the years pharmacies and their associations have complained that particular states' dispensing fees were unreasonably low. We have not assessed the validity of these complaints.

In 1986 Medicaid dispensing fees ranged from $2.00 to $5.12 per prescription. Thus, there is a wide variation in the levels used by the states. However, a well-designed survey of pharmacy costs should enable Medicare to set reasonable dispensing fees if a drug program is enacted.

Estimating the pharmacy's cost of the dispensed drug to preclude overcompensating the pharmacy is more difficult. Historically, many states have used average wholesale prices (AWPs) as listed in the Redbook or Bluebook--two compendiums of drugs listing prices by manufacturer, dosage form, and quantity--as the estimate of pharmacies' drug costs. But AWPs do not reflect many types of discounts and rebates available to pharmacies and, thus, tend to overstate pharmacies' drug costs. In the mid-1970's, the Department of Health and Human Services (HHS) estimated that AWPs overstated actual costs by 15 to 18 percent. A 1984 HHS Inspector General's report on the Medicaid drug program estimated that AWPs for the drugs in the sample exceeded actual costs by an average of about 16 percent.

Another problem related to pricing is that the Food and Drug Administration has determined that a number of manufacturers and suppliers sell therapeutically equivalent formulations of many drugs.[1] In these cases, the main difference between the various "brands" of the drugs is price, and often the price varies widely. HCFA has taken action to attempt to assure that, in such cases, Medicaid does not pay the price of expensive brands of therapeutically equivalent drugs by establishing an upper limit on payments based on the cost of the lowest priced brand that is widely and consistently available. This limit is called the maximum allowable cost (MAC). But such limits have been established only for a small number of drugs, and none have been added to the MAC list since 1982. The process for adding drugs to the list and for updating MACs is cumbersome and time consuming, which at least partially explains the lack of use of the MAC program.

In the final analysis, the question of how much to pay for a drug comes down to the degree of assurance desired that the pharmacy is not overcompensated and that the program does not pay for expensive brand name drugs when therapeutically equivalent generics are available. The better the estimate of what the pharmacy pays for a drug, the more assurance the pharmacy is not overpaid. And the more incentives to dispense lower cost drugs, or only paying the price of lower cost drugs, the more assurance that high priced drugs are not paid for when equivalent, lower cost ones are available.

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[1] Often when a drug is introduced, the original manufacturer has a patent on it and sells it under a brand name. When the patent expires, other manufacturers or suppliers often sell the drug under its chemical name--called generic drugs--or under their own brand names--called branded generics. Generally speaking, generic drugs cost pharmacies less than brand name drugs.

## WHAT IS THE POTENTIAL FOR FRAUD AND ABUSE?

You asked us to address the potential for fraud and abuse under a Medicare outpatient drug program. As with any component of a health insurance program, there is potential for fraud and abuse. However, Medicare already contains provisions providing criminal and civil penalties for fraud and abuse, and the Congress is working on legislation to further strengthen these provisions.

Under Medicaid, the primary problems with fraud and abuse in the drug program include

-- charging for brand name drugs when lower priced generic drugs were dispensed and

-- billing for services not rendered.

States normally require pharmacies to retain prescription forms and other records on drugs purchased and dispensed. If Medicare were to cover prescription drugs, current Medicare law would make such records available to the program. The current record requirements, combined with the severe penalties for defrauding or abusing Medicare, should act as strong deterrents to fraud and abuse. In addition, the record-keeping requirements make it relatively easy to investigate cases of suspected fraud. For these reasons, we believe that, with an adequate auditing/investigative effort to give meaning to the deterrent built into law, fraud and abuse by pharmacies could be controlled.

## OTHER ISSUES FOR CONSIDERATION

### How Would Beneficiaries in Nursing Homes Be Affected?

Most nursing home patients are eligible for Medicare, and many of them are also covered by Medicaid. Drug costs for nursing home patients can be substantial. While relatively few nursing home patients have their nursing home "room and board" bills paid by part A of Medicare, those eligible for part B do have covered services paid by Medicare and would be eligible for a part B drug program.

If Medicare assumes responsibility for drugs for its beneficiaries in nursing homes, Medicaid costs would go down and Medicare costs would go up, with a net effect that states would pay less for Medicaid and overall federal costs would be higher. This would result because most states pay Medicare premiums for Medicaid beneficiaries and the federal government shares in those state payments. The same circumstances could arise for dually eligible noninstitutionalized persons.

### How Will Out-of-Pocket Costs Be Determined?

The allowable amount for drugs to be used to determine when beneficiaries meet whatever drug deductible applies should be specified in legislation. If the allowed amount is set at the amount Medicare would pay for the drugs, as is the case for other part B services, the beneficiary will not know when he or she has reached the deductible amount. This uncertainty would result because the beneficiary would normally pay the full amount charged but Medicare would recognize only the amount arrived at using its payment limitations. This could add a degree of confusion to the program and could result in more claims being submitted for processing.

On the other hand, if the actual amount paid by the beneficiary is considered the allowable amount for deductible purposes, it could somewhat lessen the incentive for beneficiaries to shop for a pharmacy with low prices.

### How Will State Drug Substitution Laws Apply?

All states have laws relating to when a pharmacist can substitute an equivalent drug for the one prescribed. These laws fall into two groups--those that require the prescriber to take a positive action to authorize substitution and those that require action to prohibit substitution.

Studies have shown that substitution is less likely to occur when the prescriber must explicitly authorize it. Under normal circumstances we see no justification for the government to pay for a more expensive drug when a therapeutically equivalent, lower price drug is available. If payment rates are set in light of the availability of substitutable drugs, pharmacists in some states could be forced to dispense a high cost drug because the prescriber did not authorize substitution but could be limited to a payment below the pharmacy's drug cost.

### Should Assignment Be Mandatory or Optional?

This issue relates to the agreements pharmacies would enter to participate in a Medicare drug program. The basic questions are:

- Will assignment be mandatory? That is, will pharmacies have to agree to accept Medicare's allowed amount as payment in full if they want to participate in the program?
- If assignment is mandatory, what effect will that have on the number of pharmacies participating?

If accepting assignment is optional, a Medicare program would not assure beneficiaries that their drug costs would be limited to the program's deductible/coinsurance amounts because they would be liable for any differences between allowed amounts and actual charges. On the other hand, if assignment is mandatory, at least some pharmacies might choose not to participate.

There are indications that mandatory assignment would probably not greatly affect participation. As you know, assignment is mandatory under the Medicaid program, and states have been able to enlist most pharmacies to participate. There is also precedent in Medicare for mandatory assignment. Independent clinical laboratories must accept as a condition of participation Medicare's laboratory fee schedule amounts as payment in full, and the vast majority of laboratories participate. Finally, if a Medicare drug program is catastrophic in nature--that is, it has a relatively high deductible--pharmacies might not want to take the chance that beneficiaries would not use them for drugs purchased before the deductible is met because beneficiaries will probably look for participating pharmacies for all their drug needs.

### What About Drugs Already Covered by Medicare?

Medicare currently covers one type of outpatient drug--immunosuppressant drugs, needed after organ transplants, for a maximum of 1 year after such an operation. If a Medicare drug program is enacted, the Congress should specify whether immunosuppressant drugs fall under the new program and, if so, whether the coverage for such drugs would be extended beyond the current 1-year limit.

This concludes my statement; I will be pleased to respond to questions.

Chairman STARK. You mean a flat dispensing fee——

Mr. ZIMMERMAN. $2 or $3.

Chairman STARK. As opposed to a percentage.

Mr. ZIMMERMAN. That is correct. Some flat fee.

Chairman STARK. How do you answer the question that if you have a $10 prescription and you have a $3 dispensing fee, it is at 30 percent; and if you have a $60 prescription, it is 5 percent.

Mr. ZIMMERMAN. That is the way it is; $3 is $3.

Chairman STARK. $3 is $3. Do you think that is an administrative simplification?

Mr. ZIMMERMAN. I think so. I think it makes it easier if people know what their share is going to be. I could see, given the nature of the drugs that were being discussed by the earlier witnesses, I think it would be very hard for people to figure out what their 20 percent costs are.

Mr. DOWDAL. It would also eliminate the pharmacists having to send a bill to the beneficiary after they determined how much Medicare was going to allow for the particular drug and things like that.

Chairman STARK. Let me just go back to your testimony. Insofar as the costs of the drugs and the system of dispensing them and the wholesale costs and the operational cost, is there any data or any statistics which are unavailable to GAO or to the Congressional Budget Office?

Are there any studies that you can think of that would produce any data that is not current and readily available to us?

Mr. ZIMMERMAN. I am not aware of any. Maybe Mr. Dowdal is.

Mr. DOWDAL. I am not sure I understand what you are asking.

Chairman STARK. Well, it has been suggested perhaps we should have a study; this has been a rather general suggestion. So my question to you gentlemen is: If we were to have a study, what data would you ask for? Is there any that is not available in the experience of the Medicaid programs or HCFA's programs or private insurance or State programs?

Mr. DOWDAL. I do not know offhand of any particular area where there is not already knowledge about it. If you had a new study, it would be more updated data, I suppose, but the areas have pretty much all been covered. There has been a lot of research in the area.

Chairman STARK. Thank you.

Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

If there were a determination to take some modest steps in this direction and try to gain some experience before we went into it on a full-fledged basis, do you have any thoughts as to what would be involved if we were, for example, to require that every State include under its Medicaid program outpatient prescription drugs up to 100 percent of the poverty line?

I was just thinking this when I listened to the earlier witnesses. Maybe that is the way to go—to focus this benefit on the folks who are in the greatest need, and also to build upon what you have already told us about the experience under the state Medicaid programs which do not uniformly provide protection up to the poverty line, but which do in many states involve some actual experience in working with this program.

Do you have any comments on that thought?

Mr. ZIMMERMAN. Well, that is certainly an option to proceed with an expanded Medicaid benefit, it is just as viable an option as the option I think that is being considered here.

Mr. DOWDAL. Of course, it would not cover everyone that would be covered by a Medicare benefit, because when you talk about the poverty level, when you are figuring out a person's income, you normally do not take out the medical expenses. So someone who has an income above the poverty level but has very high drug expense still would not be covered.

Also, if you did that, I would suspect that that would actually increase Federal expenditures because under Medicaid you do not charge a premium, normally, to the beneficiaries. So State and Federal funds would have to be used, and there would not be premiums or a tax directly related to the drug coverage.

Mr. GRADISON. Thank you. Thank you, Mr. Chairman.

Chairman STARK. Mr. Coyne.

Mr. COYNE. Thank you, Mr. Chairman.

I wonder if either of the witnesses have any concerns about the States possibly terminating their program as a result of the implementation of the Federal program. Would you foresee anything like that possibility?

Mr. ZIMMERMAN. I do not see any reason why they would at this point.

Mr. DOWDAL. There would still be the $500 deductible. For their Medicaid recipients I would not think they would want to dump $500 on them that they would have to pay on their own. What you are talking about is once a person got to the limit, $500 deductible, or whatever, the State's expenditures would then go down because they would be covered more by Medicare. So the States would have lower Medicaid expenditures.

Mr. ZIMMERMAN. Actually, the States stand to gain probably and pay less for the beneficiaries that are covered by the catastrophic provision.

Mr. COYNE. Thank you.

Chairman STARK. Mr. Moody.

Mr. MOODY. Did I hear you say that you prefer the flat $3 copayment to a percentage copayment?

Mr. ZIMMERMAN. That is correct. A flat payment.

Mr. MOODY. If one of the goals is to hold the costs down and to provide a continual incentive for keeping costs down, it seems to me that would be lost once you pass the $3 threshold, as opposed to a percentage under which there is a continual incentive on the part of the recipient to make the order no larger than necessary because they are always paying some fraction of it.

It seems to me that the continuity of the pressure is much better with the percentage than with the flat copayment.

Mr. DOWDAL. Well, what we are basically suggesting for your consideration is that for ease of administration a copayment makes it a lot easier to administer. On the other side, referring to using generics versus brand name drugs, the incentive there could still be built into the reimbursement mechanism that is use for multisource drugs.

Mr. MOODY. Yes. There may be other ways of keeping costs down, such as generic drugs, but that certainly should not be the only way we try.

You do not disagree with what I am saying. You simply say there is an administrative benefit by doing it as a flat number? Am I understanding you correctly?

Mr. DOWDAL. Right. It would be a lot easier to administer a program with a copayment than it would be with coinsurance. It makes the program also a lot more understandable to the beneficiary. They know that when they go in to get a drug, they are going to pay $3 or $4 or whatever it is, and that is it. They do not have to worry about some time later getting a bill from the pharmacy for the remainder between what Medicare allowed and what Medicare paid, the coinsurance part.

Mr. MOODY But it would tend to induce people to load up, as it were, on the pills or whatever they need because a single order would have a $3 copayment as opposed to the percentage system. Under a percentage you would not have any benefit by loading up now.

Mr. DOWDAL. It would also benefit the Government, or the Medicare program if they have a maintenance drug and they get enough for a longer period, get a 60-day supply instead of a 30-day supply, because then the Government would only pay one dispensing fee. So, in effect, both Medicare and the beneficiary would save money.

Mr. MOODY. Yes, but the Government would only pay—if you made it a percentage copayment, let us say 80 or let us say 60 percent—the Government is only paying 60 percent of this loading up rather than everything above the $3. Do you see what I am saying? The lines would cross somewhere, but it would not have to be a very big order before the Government started to save money, more money, under a copayment system than under a flat fee system.

Mr. DOWDAL. Yes. The coinsurance on high cost drugs and prescriptions could well be higher on a 20 percent coinsurance on a $30 drug is better than a $3 copayment from the Government's standpoint of how much it is going to pay.

Mr. MOODY. And as those costs go up over time with inflation, et cetera, the $3 becomes smaller and smaller and smaller. And unless we index the $3, which we probably would not do, it would eventually become fairly insignificant; whereas, a proportional relationship is independent of inflation.

Mr. DOWDAL. Right.

Mr. MOODY. Thank you.

Chairman STARK. Mr. Gregg.

Mr. GREGG. What is the total number of dollars spent on drugs by senior citizens?

Mr. ZIMMERMAN. I do not have any information on that. I am sorry.

Mr. DOWDAL. I think one of the senior associations has recently estimated that it is something in the neighborhood of about $8 billion, I believe.

Mr. GREGG. Do we have any independent numbers on that figure?

Mr. DOWDAL. As far as I know, there are no recent Government numbers on that.

Mr. GREGG. I thought your testimony was that you had all the numbers you needed in this area.

Mr. DOWDAL. All the numbers you need for what? There are studies, as I said. I believe it was AARP that just had a study that they have recently done that did a lot of estimating of average drug costs and how many people go above certain ranges, dollars-per-month ranges. There is a lot of data on that.

Mr. GREGG. How does GAO substantiate its conclusions if you do not know how much is spent on drugs in this country by senior citizens? I mean, that seems to me to be a basic starting point.

Mr. DOWDAL. We have not advocated or endorsed a particular bill. We were asked to testify on the subject based on our experience, the kind of big issues the committee should consider, and we have not taken a position on whether or not the Congress ought to actually enact this or that proposal.

Mr. GREGG. If you were asked to take that position, would you not need that information to begin with?

Mr. DOWDAL. How much the program would cost?

Mr. GREGG. Well, yes.

Mr. DOWDAL. We would have to know that in order to determine whether the premium that was being proposed was adequate to cover the costs of the program and actuarially sound and all that kind of stuff.

Mr. GREGG. So would your counsel to this Congress be that we should at least have that number to start this program with?

Mr. ZIMMERMAN. I would assume there is a number being set forth as to what the estimated cost of the new provision is and the various alternatives to the proposal. Yes, I would definitely say you would have to know what is the premium going to be, you know, what it is going to cost.

Mr. GREGG. In your studying of the various Medicaid experiences, did you go over the estimates that New York State and New Jersey had anticipated that their drug program would cost prior to instituting those drug programs?

Mr. ZIMMERMAN. No. I am not aware that we did. Maybe Mr. Dowdal is aware.

Mr. DOWDAL. Are you talking about the initial Medicaid drug programs back 15 or 20 years ago?

Mr. GREGG. Right.

Mr. DOWDAL. No. Not that I would know of.

Mr. GREGG. You did not ask what these people through their programs were going to cost when they started? That question was not asked, I take it.

Mr. DOWDAL. No.

Mr. GREGG. Well, let me ask this question. If it is shown that what they thought it was going to cost when they started and what it cost almost immediately after it was begun was substantially different, and it was shown that the difference involved multiples in higher costs, can we anticipate that something occurred that was not expected? Would those type of figures reflect something occurring——

Mr. ZIMMERMAN. It would reflect a bad estimate.

Mr. GREGG. A bad estimate.

Mr. ZIMMERMAN. Yes. They may not have had sufficient data to make a good estimate for the Medicaid population at that time because there was nothing available.

Mr. GREGG. Applying the same fact pattern to this instance today, what would be sufficient data to give us a firm estimate of what this program is going to cost? If you were setting up a structure as to what type of numbers you would need in order to get a firm handle on the cost of this program so that we would not end up like New York or New Jersey did, what would be some of the black letter areas that you would have to have numbers on?

Mr. DOWDAL. Since you are talking about a program with a deductible, you would want to know what percent of the population went above that number, and for the people who went above that number what their average expenditure was in excess of the deductible amount. That would be the primary numbers that you would need.

Mr. GREGG. Would there be any way of calculating how many people out there might be drawn into the system who are not now participating in the system? In other words, the woodwork factor.

Mr. DOWDAL. What you would be concerned about there would be the number of people who do not get prescriptions now because they cannot afford them.

Mr. GREGG. Right.

Mr. DOWDAL. And, technically, that could well be costing you more money on the other programs because they are not getting the drugs they need to keep healthy. But, anyway, that would——

Mr. GREGG. Would not that be a number you would need, though, to make an estimate on?

Mr. DOWDAL. That would be a number that would help to make a better estimate, yes.

Mr. GREGG. How would you arrive at that number? Is there any evidentiary information available on that?

Mr. DOWDAL. I believe the latest AARP study has some of that kind of data in it: the number of people who say they forego getting prescriptions because they cannot afford to pay the price.

Mr. GREGG. And would you also have to have a sense of historical and projected costs of drugs is in this country? Would you need that?

Mr. DOWDAL. I think drug cost growth estimates for the future, yes.

Mr. ZIMMERMAN. I think the information on the historical drugs is available.

Mr. GREGG. How about projected drug costs?

Mr. ZIMMERMAN. I think the historical ones could probably be projected to come up with a future cost.

Mr. GREGG. In getting your projected drug costs, are you going to have to come up with a figure for new drugs? In other words, would you have to factor in the current dynamic situation in the area of new drug development and the escalating cost of drugs is as a result of new discoveries, and that these new discoveries are to be expected? Would you factor that in somehow?

Mr. ZIMMERMAN. It would seem to me that if you wanted to get the best possible estimate you should consider many of those factors. I am not that familiar with the escalation in drug cost or the escalation in expansion of new and more expensive drugs, so I cannot say to what extent that will influence the overall long-term estimates.

But to the extent that information is available and the drug industry has it, they have their ideas on it and I think it should be used.

Mr. GREGG. Do you think it is available?

Mr. ZIMMERMAN. I think they are in business. I think they know what the market looks like. I think they have got plans. To the extent they will want to share that, it would be helpful.

Mr. DOWDAL. What you are really discussing here is additional kinds of information that will make any estimates you have a better estimate.

Mr. GREGG. Right.

Mr. DOWDAL. And more reliable. There is information on many of those issues. As with any kind of forecasting, you can forecast what is going to happen the next year or the next three years usually fairly accurately. If you start talking about longer term down the road, 10 years from now, you get more in the area of a guess. From year to year, you should be able to make a fairly good estimate.

Mr. GREGG. Well, you folks are professional forecasters. If I were to ask you to pull together a list of some of the things we just went over, and other ideas that would have to go into forecasting the costs of this program—I am not asking for the numbers. I am asking for a list of what those areas would be—and then whether that information is available, could you do that before Thursday when we are going to mark up this bill?

Mr. ZIMMERMAN. I do not think we could do it before Thursday.

Mr. DOWDAL. I would not think so either, but I assume that CBO has been asked to make a projection on this bill. They would probably be able to give you better and faster information than we could.

Mr. ZIMMERMAN. I assume they have a head start already.

Mr. GREGG. Well, if we wanted some independent input.

Mr. ZIMMERMAN. We would be glad to look at what CBO puts together and add our advice to what they have, but to start today trying to gather this data, I think would be almost impossible.

Mr. GREGG. I do not want the data. What I want is a list of the criteria and a list of whether the data sources are available.

Mr. ZIMMERMAN. That would be very difficult for us to track down data sources at this late stage and have something by Thursday. Again, we would be more than glad to look over the CBO estimate and see if there is anything that we think that is missing that should be included at this point in time.

Mr. GREGG. But you think $18 billion is the approximate figure of what is presently being spent on drugs by senior citizens?

Mr. DOWDAL. I think the number for the elderly was between $8 and $9 billion.

Mr. Gregg. $8 and $9 billion. Thank you. I do not think you can properly evaluate the CBO figures adequately in a day-and-a-half either, but any information you could send us would be helpful before Thursday.

Chairman Stark. Mr. Pickle.

Mr. Pickle. Thank you, Mr. Chairman.

The subcommittee has made a recommendation for an approach to this bill, and they have estimated that the costs for the first year, 1989, would be $760 million and $1.3 billion in 1990. I believe that was the estimate.

I am not certain that in your response to Mr. Gregg that you answered the question. Are those figures in line with your estimate, or are they low or high? What would you estimate would be the cost for 1989 and 1990?

Mr. Zimmerman. Mr. Pickle, we did not study the cost estimates for this proposal, so we do not have any information.

Mr. Pickle. You do not know whether those figures——

Mr. Zimmerman. No, sir.

Mr. Pickle. There is no way you could make an estimate.

Mr. Zimmerman. We do not know.

Mr. Pickle. Based on the recommendation that has been made to this committee, could you give us that estimate of cost by Thursday?

Mr. Dowdal. No.

Mr. Zimmerman. I do not think so. Again, I think the best thing we can do between now and Thursday would be to go look at what CBO has done and see if we see anything there that is apparent that has been overlooked and should be considered.

Mr. Pickle. All right. I did not get to hear all your testimony since I came in a little bit late from a meeting, but did you get into a description of what you would call catastrophic? When do you reach the point where one should be covered by catastrophic prescriptions?

Mr. Zimmerman. No, we did not. Basically, my testimony covers operational problems and issues that we think the committee should consider in framing a legislative package in terms of what should be the catastrophic limit or whether we should have catastrophic drug provisions.

Mr. Pickle. Well, the committee has first recommended we start with a deductible of $400, and now the latest recommendation is a $500 deductible. Do you have any view of whether this is an accurate figure?

Mr. Zimmerman. Well, it sounds to me like there is a money problem there. The higher the deductible goes, the less you are going to have to pay——

Mr. Pickle. I am asking you as one who made a study of it. Is that $500 level a good figure?

Mr. Zimmerman. Referring to the study that Mr. Dowdal referred to earlier, I think it shows that about one-third of the people buying prescription drugs would benefit from a—is it a $500 or $400 deductible?

Mr. Dowdal. Somewhere in the area of about 30 percent of the elderly who use drugs.

Mr. PICKLE. If we are going to have a deductible, our committee is asking ourselves what would be the level? I am asking you as experts, what the deductible level should be?

Mr. DOWDAL. That is basically a policy decision, Mr. Pickle, on what extent of the people you want to cover who would get benefits from it.

Mr. PICKLE. Well, I am not asking you to give me an estimate if you do not know what it is, but I am trying to get information I can put my hands on and not just have a handful of air.

Is it a $400 level, a $500 or $600 level appropriate? If you have any viewpoint, we need to know. We would like some estimate if you have one.

Mr. DOWDAL. We do not have one on that, Mr. Pickle.

Mr. PICKLE. I am making a recommendation with respect to the copayment. You and Mr. Zimmerman have recommended the copayment rather than a percentage.

Mr. ZIMMERMAN. We recommended that you consider it. We think it is a viable option that should simplify things and make it easier for the beneficiary to understand.

Mr. PICKLE. Your approach is more on the simplification of administration rather than on the strict fairness of it.

Mr. ZIMMERMAN. That is correct. Copayments, it is my understanding, have been used in other drug programs, and it is an acceptable way of dealing with it.

Mr. PICKLE. The committee has also recommended with respect to the premium. $1.95 plus 10 percent of the supplemental estimate of income. That would be approximately 50–50.

When the committee passed the catastrophic bill we kept the premium exceedingly low; in my judgment, too low; but we did, anticipating that if we got into prescription drugs those costs would go in the premium.

Now, we come back with the cost, half of it in the premium and half on the income base. Do you have any feelings whether the premium should come more from the premium or more from the supplemental income, or do you have an opinion?

Mr. ZIMMERMAN. That is basically a policy decision on the part of the subcommittee, and we really do not have an opinion one way or the other.

Mr. PICKLE. We have asked a lot of questions, and you all come back to it as a matter of policy. Of course it is, but we need some facts to make the policy decisions.

Finally I would ask this. There is an urgency for this type of coverage, and the Congress must face it at some point whether it would move forward now or not. Do you have any feeling, in view of the many unanswered questions, of whether we should have a study done on this approach, or should we go ahead and try to work it out the best we can?

Mr. ZIMMERMAN. Well, Mr. Pickle, so I do not repeat myself on the issue of policy questions, let me say personally I think you ought to move forward with the proposal. I would personally think it is a step in the right direction. From a policy perspective, GAO has not studied it.

Mr. PICKLE. Thank you, Mr. Chairman.

Chairman STARK. We are pleased to have Mr. Duncan here. Would you care to inquire?

Mr. DUNCAN. Thank you, Mr. Chairman. I have no questions.

Chairman STARK. Mr. Donnelly.

Mr. DONNELLY. Thank you, Mr. Chairman.

Correct me if I am wrong, but did you say in response to a question from my friend from New Hampshire that the out-of-pocket expenses for the elderly's prescription drugs are $8 to $9 billion a year?

Mr. DOWDAL. I am trying to remember numbers from a study that AARP did, and I believe that was an overall number and I think they said about $7 billion.

Mr. DONNELLY. Who told you that? Where did you get those figures? From what organization?

Mr. DOWDAL. From AARP.

Chairman STARK. Would the gentleman yield?

Mr. DONNELLY. I would be happy to yield.

Chairman STARK. I am informed by the staff that the CBO figure that they have used in the estimate, which we will have present in our markup, is $6.5 billion. At one point it was higher, but I think that is current CBO estimate that they have used.

Mr. DOWDAL. I just found a summary of the AARP study, and it says the overall drug expenditures for the over-65 was $9 billion. Since some of them have coverage under Medicare supplement policies or whatever, their out-of-pocket was estimated as $7.3 billion.

Mr. DONNELLY. That is an AARP study.

Mr. DOWDAL. Right.

Mr. DONNELLY. Were you aware of the CBO estimate?

Mr. DOWDAL. No, sir.

Mr. DONNELLY. Are you aware of any other agency of the Federal Government that has made an estimate on these out-of-pocket expenses?

Mr. DOWDAL. They have been made over the years a lot of times, but recent ones I am not aware of.

Mr. DONNELLY. Give me the most recent example of a HCFA or any Federal Government agency that has made an estimate of out-of-pocket expenses.

Mr. DOWDAL. The last time that it came up I believe was in 1979. There was a proposal.

Mr. DONNELLY. 1979?

Mr. DOWDAL. I believe, to include coverage.

Mr. DONNELLY. A second question——

Mr. GREGG. If the gentleman would yield?

Mr. DONNELLY. Sure.

Mr. GREGG. It is my understanding that HCFA is going to give us some numbers. I am told by staff that their figures on an average basis will be higher than CBO, but I do not know what the figure is.

Mr. DONNELLY. My second question. Do you know of the average annual increase in the cost of prescription drug coverage under the State Medicaid programs for the last 5 years?

Mr. DOWDAL. Those numbers are available. I do not know them off the top of my head.

Mr. DONNELLY. Mr. Zimmerman?

Mr. ZIMMERMAN. No.

Mr. DONNELLY. Well, I have them. In just the last year that we have, 1984-85, there was a 17 percent increase. It has averaged about 13 percent from 1980 through 1985.

Question 3: Do you know what the savings to the States would be if we adopted an approach such as the chairman recommends, a $500 deductible? There will clearly be some savings. There will be a Medicaid offset. Are you aware of what those savings would be?

Mr. DOWDAL. The basic savings would be that the amount that the beneficiaries themselves would pay under whatever way it is ends up being financed. Under the way it usually works, the State pays the premium for the Medicare/Medicaid, dual eligible person, so the difference, then, would be—the savings would arrive from the amount that was funded through a tax or whatever kind of way you would end up doing it.

Mr. DONNELLY. But are you aware of any number? Has anybody asked you to look at a number of what potentially overall savings would be to the 50 States—well, 48 States; there are two states that have no program—and how that would break down? Who would be the winners and losers if we adopted a approach that some people have endorsed?

Mr. ZIMMERMAN. Well, the States that have the higher share.

Mr. DONNELLY. The larger States.

Mr. ZIMMERMAN. Yes.

Mr. DONNELLY. But do you have a dollar figure?

Mr. ZIMMERMAN. No, we do not have a dollar figure.

Mr. DOWDAL. Roughly 6 percent of Medicare costs are for drugs, and a large number of those people would end up not being covered by a Medicare program.

Mr. DONNELLY. I guess the case that I am trying to build is that in the response to the question from the chairman, you said that all the information that was necessary was available for the Congress to make policy decisions.

Chairman STARK. Would the gentleman yield?

Mr. DONNELLY. If I could just finish, Mr. Chairman.

And then I asked you three specific questions. We do not know how much the elderly spend in out-of-pocket expenses on prescription drugs. You people do not, other than what AARP tells you.

Chairman STARK. Would the gentleman yield?

Mr. DONNELLY. Just let me go through my two other points.

Second, you do not know what the average increase has been for the State-run programs, a place where we have practical experience. And, three, you do not how much the States are going to save. Before you make a recommendation or you make a statement that all the information is necessary, there should be some basic information that you should look at.

Chairman STARK. Would the gentleman yield?

Mr. DONNELLY. I would be happy to yield.

Chairman STARK. In defense of Mr. Zimmerman and Mr. Dowdal—and it is the Chair's fault—these gentlemen were not asked to testify as to the overall total cost of the program. They were asked to testify in areas of fraud control, abuse, and administration. It was to that end that I think they do have all the information.

CBO will be asked to testify.

Mr. DONNELLY. But they did, in a response to a question from you, Mr. Chairman, make the statement that all the information was available.

Chairman STARK. Relative to what they were asked to testify to, they have that. And I am afraid we have assumed, and I did not correct that impression, that they had all the information about the entire universe of beneficiaries, and they do not. That is CBO's realm.

Mr. DONNELLY. It is not asking for the information of the universe to ask if anybody has a clue what the elderly are spending in out-of-pocket prescription drug expenses. That would seem to be the first——

Chairman STARK. That alludes to the CBO study, and they will be asked to testify to that.

Mr. DONNELLY. I think before a government agency gives us advice on policy decisions and gives a direct response to whether all the information is available and collected and people are knowledgeable about it and they cannot answer three basic questions, that creates the controversy. I am not trying to create something here, Mr. Zimmerman, but I think you are picking up some sense of concern by the membership of the committee about the potential overall cost of this program, and the lack of data that is available for us to make the policy decisions that are inevitable on this issue, and some other issues as it deals with the health care for our elderly citizens.

Mr. ZIMMERMAN. Well, I would expect, Mr. Donnelly, that before this subcommittee acts on the legislation it will have that information available to them.

Mr. DONNELLY. We are acting tomorrow.

Mr. ZIMMERMAN. Well, I hope the CBO will be here and able to deliver the information to you.

Mr. DONNELLY. Let me ask you on the issue of mandatory assignment, where I think we might have some areas of agreement. When you looked at mandatory assignment as it relates to the Medicaid State-run programs, you are making some assumptions that since they are forced to participate, since they cannot balance bill, then if we put mandatory assignment in a Federal Medicare prescription drug program, that it would be fairly simple for those pharmacies to move into the Medicare program.

Am I overstating your case, or am I assuming things that are not in your testimony?

Mr. DOWDAL. What we are saying is there are some indicators that it may not have a large effect on participation and some of those are, is that Medicaid has mandatory assignment, and a large number of pharmacies participate in that program. A Medicare program is being discussed that only would not cover the first $500, and one would think that they would want to be able to put up—that the pharmacies would take Medicare so that beneficiaries will not be concerned about going to a pharmacy where they will have to switch once they reach the deductible.

Mr. DONNELLY. After they pay the $500, they're going to have very little left to pay for anything else.

Mr. DOWDAL. Right.

Mr. DONNELLY. There has been a question raised on rural pharmacies in less populated areas of the country. Has there been a problem with this mandatory assignment for Medicaid in rural areas that you are aware of?

Mr. DOWDAL. I know there have been many complaints from rural pharmacies that the Medicaid level of the dispensing fee was not adequate to cover their costs, because they cannot get the economies of scale that large urban ones can. You know, there is a big variation in Medicaid dispensing fees running anywhere from $2 up to $5.

Mr. DONNELLY. I guess my question is on pharmacists participating.

Mr. DOWDAL. As far as I know, the majority of the rural ones also participate in the program. Medicaid has got a lot of problems with getting enough providers to furnish services to its beneficiaries, but pharmacies is one of the ones they have not had as much problem with.

Mr. DONNELLY. Well, thank you, gentlemen. I did not mean to be combative with you at all, but I think it is fair at a forum like this to ask some of those questions, because we are jumping into a pretty big hole here.

Mr. DOWDAL. When I was responding to a question that was asked, whether information was available—and I know there are a lot of studies and data out there—we have not got it ourselves. But there is a lot of information.

Mr. DONNELLY. I would just like to see us relying upon some Federal Government studies from our own agencies, rather than people that might be affected, either in a positive or a negative way. The AARP or the pharmaceutical industry, it would seem to me that is not a strong foundation to build this house on.

Mr. DOWDAL. GAO is always in favor of having good information on which to base decisions.

Mr. DONNELLY. Thank you very much.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Thank you, Mr. Chairman.

Let me ask GAO a few questions about the areas they were supposed to study, because I think you have clarified the focus of their study. It was not on the overall cost of the program.

I would add to Mr. Gregg and others that a program can cost more than expected because of need as well as other factors. If a program costs more because of need and not because of other factors, it means it is responsive to something that was even more aggravated than understood by the Congress, and that is not bad. I personally felt the answers of Ms. Smith and Mr. Shulman concerning why Medicare should cover prescription drugs rather than long-term care had some cogency to them.

One reason a program can cost more than expected is not only because of need but because of cost control. That was really, as I understand it, a major focus of your study. So let me ask you about that because I am sure in the next few days, it will be a focus of attention, as it should be.

Your bottom line is kind of a cheerful one, as I read it, that we can contain the cost of this program, that we have experience through Medicaid that gives reason to believe that we know what we are doing in terms of reimbursement.

Let me just push you on that a bit. On page 2 you indicate various factors of reimbursement and control of cost. You say that the second payment limit is a valid check on the reasonableness of pharmacy charges. Let me just ask you to elaborate, if you mean by valid effective, because that is part of the nub of this issue.

On page 3 you go on to say that estimating the pharmacy's cost of the dispensed drug to preclude overcompensating is more difficult, and you talk about average wholesale prices which would be one of the bases for cost containment here.

So if you would, just tell us a little more about your optimism on cost containment here. Again, it is one thing if the costs go way up because we underestimated need. I do not quite like the woodwork analogy, I must say, because I think it tends to minimize the need involved. There is some implication that people do not have need; they just all of sudden, because there is a program, are coming out of the air, if not the wood.

But there is, I think, a legitimate question that we must face in advance about cost containment. So if you would, tell us a little more about why you think these mechanisms are likely to work based on the Medicaid experience.

Mr. DOWDAL. Well, I think the primary one, the first limit dealing with charges to the general public is just to make sure that the program would not pay more than someone who just came in off the street because it does not make sense to pay more.

The second one dealing with comparing what you estimate the cost to the pharmacist to be with what his charges are is a limit on charges, so that as with all other Medicare ones, the program tries not to pay unreasonably high charges.

What we talk about then, how you go about estimating the pharmacy's cost is where you can run into some problems. Again, it becomes an issue of how much do you want to be assured that you are getting as close as possible to what the pharmacist is actually paying for drugs. If you use average wholesale prices, you are going to be off if average wholesale prices are used because generally most of the studies show that average wholesale prices are around 15 percent higher than pharmacy costs.

HCFA has used other data and provided it to the States and the Medicaid program where HCFA get sample data from pharmacies. They call it part of their estimated acquisition costs, and it is done by percentiles. The lower the percentile you use, the more, you know—the more of that kind of stuff you put in, of course, the more complicated the administration of the program becomes.

What we were saying is that from the standpoint of a Medicare program, you can put in whatever level of controls you want to get to the point that you have the assurance you feel you need that the amount paid for a particular drug is going to be a reasonable amount.

Mr. LEVIN. But we are trying to get away in other areas, hospital payments, physician payments, from cost plus, right?

Mr. DOWDAL. Right.

Mr. LEVIN. Now, in this area, how do we set up a system so we are not just paying whatever the market is plus? As prices go up, is this a program, as now controlled, under which we are simply going to pay cost plus?

Mr. DOWDAL. Under this kind of a procedure, what you would do if the cost of drugs to pharmacies go up, then the cost of the program would go up. The dispensing fee, which covers pharmacy cost and profit, is set at a flat level for everybody.

Mr. LEVIN. And in your judgment, that is an adequate basis of cost containment?

Mr. DOWDAL. Unless you want to get involved in directly controlling the cost of drugs from manufacturers through a price control program, which I would not assume you would want to. I do not know of any other way to do it.

Mr. LEVIN. I am not reaching a judgment. I am just ask you. You studied this area. It was clearly your mandate to do so. We are going to mark this bill up, and we need to anticipate cost in terms of the reimbursement procedures.

Maybe Mr. Zimmerman has something.

Mr. ZIMMERMAN. I would think this method would suffice, what we have set forth here and what basically you folks have included in your first cut of your proposal.

Mr. LEVIN. Is that partly because of the competitiveness within the pharmaceutical industry——

Mr. ZIMMERMAN. I would think so.

Mr. LEVIN. Plus the factor relating to the price of generic drugs?

Mr. ZIMMERMAN. That would help assure that the program does not pay for expensive drugs when it does not have to.

Mr. DOWDAL. Obviously, this kind of a program would have no effect on controlling the pharmaceutical manufacturer's price, if that is what you are concerned about. With this program, that kind of control limits deal with being sure that pharmacy costs—the program's cost of paying for the drugs from a pharmacy are reasonable, whatever the economic circumstances are.

Mr. LEVIN. I just want to be sure there is a reasonable cost containment mechanism, and to the extent the market can create that, that is fine. But you looked at this, and your bottom line, as I said, is rather optimistic in terms of cost containment based in part on the Medicaid experience.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Anthony.

Mr. ANTHONY. Thank you, Mr. Chairman.

I would like to follow up on that line of questioning, and then jump back to what Mr. Gregg and Mr. Donnelly brought up.

In your summary, you have the following statement, after you talk about Medicare being self-administered and the Health Care Financing Administration has considerable experience as a Federal administrator of the Medicaid program, you make the following conclusion: Thus, GAO does not see a lack of experience as a major hurdle to establishing a prescription drug program under Medicare. That sounds very positive.

Jump over to page 3 of your actual testimony, and you talk about in 1986 that there was a Medicaid dispensing fee range from $2 to $5.12 per prescription. You say that there was a wide variation in the levels used by the States. Then you come back with another conclusion: A well-designed survey of pharmacy costs should enable Medicare to set reasonable dispensing fees if a drug program is enacted.

So my question is simply this: Do we enact the law and then do the survey? Or do we do the survey and help use the contents of the survey to enact the law?

Mr. DOWDAL. It would depend on whether you want to specify in the law the amount of the dispensing fee, or whether you wanted to let that be set administratively by the agency that you designate to administer the program. It could be done either way, whichever way you believe is the best way.

Mr. ANTHONY. All right. Say we make a policy decision that the law should be as specific as possible and the hands of the regulators tied as much as possible.

Mr. ZIMMERMAN. Well, you could put some limits in the law if you are concerned that somebody might come back with a $10 dispensing fee or a $2 dispensing fee that no pharmacy would be willing to participate. I think you could put some limits in. I think there are indications as to what the dispensing fees are out there now, so one could set a range in the legislation.

Mr. ANTHONY. Operationally, is this a smaller or a larger problem than reimbursements under other sections of Medicare or Medicaid prescription drugs?

Mr. ZIMMERMAN. Operationally, there is going to be a fair number of transactions, very many prescription drugs, high volume, basically low cost. So it is kind of a tradeoff.

It has not proven to be an expensive aspect of a health insurance program to administer. The indication I have is it is probably one of the least costly components on a per claim basis of a program to handle.

Mr. ANTHONY. One of the witnesses that will be testifying later today quotes from a study done at the Appropriations Committee, and it talks about the cost of prescription drugs being a certain percent of the overall cost of Medicaid, but in terms of the administrative costs it was approximately 8 percent cost to the program but 50 percent cost administratively. That seems to fly in the face of your comment.

Mr. DOWDAL. I think what Mr. Zimmerman meant was that on an individual claim for a drug is relatively inexpensive claim to process. They have a lot of claims for drugs under a Medicaid type program where each time the beneficiary gets a drug, a claim is submitted for that drug. Under one with a large deductible, there would not be as many claims.

Mr. ANTHONY. So operationally and administratively, you do not see any problem in taking the prescription drug provision and putting it into the Medicare system? You do not think we are biting off any more additional problems?

Mr. ZIMMERMAN. I do not think it is going to be an extremely easy task. I think it is do-able. It is being done in 48 States under the Medicaid program. I think it is going to take a certain amount of commitment on the part of the agency that is responsible for the provision to make sure that the resources are in place, that the carriers are ready and up to speed, and that they are prepared to manage the program.

Again, I do not think it is a very easy thing to do, but I do not think it is an impossible thing. And I definitely think it is do-able.

Mr. ANTHONY. Was it part of your charge in preparing your testimony to assess the success rate of the States' programs and to make some assessment of how they would be operational if there were a federal law imposed?

Mr. ZIMMERMAN. We were not asked to look at—are you talking about the impact of a Medicare program?

Mr. ANTHONY. On a State program.

Mr. ZIMMERMAN. No, we were not asked to do that.

Mr. ANTHONY. And of the approximately 15 States that are trying to go further with some of their programs, again, it was not part of your mandate to analyze what those States have done and what their experience would mean to us in terms of how we should define a Federal law? That was outside your mandate when you prepared your testimony?

Mr. DOWDAL. Right. We were basically asked to use our experience with the Medicaid drug program and our knowledge of the Medicare program to identify issues that the subcommittee should consider while it is designing any benefit that it may decide to design.

Mr. ANTHONY. Well, the administrative costs of a State program would be something we should be interested in, right, in defining and drawing up a Federal program?

Mr. ZIMMERMAN. I would agree.

Mr. DOWDAL. Sure.

Mr. ANTHONY. You would agree with that.

Mr. DOWDAL. Yes.

Mr. ANTHONY. So if we found that the administrative costs were very large in relationship to the program, we should figure out some way to hold down the administrative costs. So we could learn from the States on that.

Mr. DOWDAL. Yes.

Mr. ANTHONY. But we can get that from somebody else that has the data.

In terms of developing a formulary, was that within your mandate when you studied the Medicaid program and compared it to the Medicare program to make a recommendation to this committee?

Mr. DOWDAL. We have looked at formularies under the Medicaid program, yes.

Mr. ANTHONY. Was that part of your mandate? Did you study them and make any comparison, and do you have any recommendations that you could make on that today?

Mr. DOWDAL. The main use of formularies by the States on Medicaid has been to preclude very high cost drugs when there are lower cost drugs available with the same therapeutic effect, and also to restrict certain types of drugs, in the controlled substance area mainly, that they did not want to provide under the program.

So the formulary has been used as a cost containment kind of program by the States in those two respects and could be used the same way under Medicare if it is desired to use it that way.

Mr. Anthony. But was that part of your mandate to study that in detail and make any recommendations to us in drawing up a formulary section if we go for prescription drug legislation?

Mr. Dowdal. We were not specifically asked.

Mr. Anthony. You specifically were not asked. But you think the experience is out there, the data is out there, if we could bring it all together?

Mr. Dowdal. For example, California has a relatively restrictive formulary and other States have very open formularies, and it gives you data to compare among various states that will show you what the difference is if formularies are used.

Mr. Anthony. Would that be a wise thing for us to do to compare that data before we try to design a section on formularies in a Federal law?

Mr. Dowdal. Well, it would never hurt.

Mr. Anthony. It would never hurt?

Mr. Dowdal. Right.

Mr. Anthony. Would it be rational, logical?

Mr. Dowdal. If you want to use a formulary as a cost control mechanism, yes.

Mr. Anthony. So it would be rational, it would be logical to try to pull all that data together before we would act on Federal legislation to see what the State's experiences had been.

Mr. Dowdal. Right.

Mr. Anthony. The data is out there, you see.

Mr. Dowdal. The Health Care Financing Administration has it.

Mr. Anthony. But you do not have the data.

Mr. Dowdal. Not here.

Mr. Anthony. Turning to questions that had been asked earlier, because it really goes to the key question I asked of the two witnesses and their representative associations in terms of timing. Not saying that anybody is opposed to putting in prescription drugs, because I am not opposed to it. But I must tell you I have a great deal of concern about the timing.

The questions that were asked and the answers that were given have just heightened my anxiety. It appears to me that what you have said in response to other questions is that you think there is a lot of data out there, and the data could be pulled together and the data could be analyzed.

But even over and above that, you made the personal assessment that even if that data is not pulled together and if that data is not analyzed, that you think we ought to go ahead and move on prescription drugs federally. I think that was Mr. Zimmerman's comment.

Mr. Zimmerman. That was my personal opinion.

Mr. Anthony. That was your personal comment.

Now, if you were on the opposite side of that table and you were sitting up here and you had to make the votes on Thursday, would you feel as confident with that position, knowing the data was out there but not knowing exactly what the data said, not having anybody pull it all together and really analyze it and give a constructive overview of it? Or would you just say, ah, the data is out there and I am going to vote for it because it makes me feel good and because I know there is a need and I know there is a cost out there, and we will just solve the problems later on?

Mr. **Zimmerman**. I do not know just what data gathering the subcommittee staff has done in advance of the hearing.

Mr. **Anthony**. Well, what if I told you I do not have any from the staff on my desk at the moment? Would that make you feel good?

Mr. **Zimmerman**. I would certainly want to know a little more about it.

Mr. **Anthony**. Would you be willing to go vote Thursday with that type of information?

Mr. **Zimmerman**. I think I would go talk to the chairman about it and ask him, How do you feel about this?

Mr. **Anthony**. I think he is getting the message right now.

Mr. **Zimmerman**. Let me say that we are not dealing with cost information in our testimony. Again, I know it is hard for you to accept this. Maybe you accept it, but you do not like it. I think the data is out there. We can try like our darndest for the next day or so to run around and gather up stuff for you if you think that will help. I do not know the reason behind Thursday, whether it can be a week after Thursday or whether there is any imperative that makes Thursday the day.

Mr. **Anthony**. I guess, Mr. Zimmerman, that is the key question I keep asking. What is magic about Thursday, the first week in June, when we have been living with this problem for a long time? And there are some serious concerns, and we are going to be forced to vote on Thursday when we are not going to really be settled in our own minds exactly what we want to do.

I guess if there is any final plea that I am making through questions that I am asking of the witnesses is to try to get a little backup support in the record that that would be a rational thing to do—not to stop it, but just to have it proceed in a more rational process.

Mr. **Zimmerman**. Hopefully, some of that rational process could be built into the legislation itself.

Mr. **Anthony**. Well, I thank you and I thank you for your contribution. I yield back to the chairman.

Chairman **Stark**. I want to thank the witnesses again and apologize to them for putting them in a position to testify beyond what they were requested to.

Mr. **Donnelly**. Mr. Chairman, I just want to——

Chairman **Stark**. I will recognize the gentleman in a moment. I just wanted to extend my own apology to the witnesses. You can talk to them anywhere you can. I am afraid that I misdirected the intent of the testimony you were asked to give today. As I say, I appreciate your being here and look forward to calling you back.

Mr. **Donnelly**. If the gentleman would yield. The two gentlemen from GAO stated the charge, but they stated beyond the charge that all of the information was available for the decision to be made, which was beyond the charge and which was in response to your question. Clearly, they should not be asked questions either from the Chair or from myself beyond the charge that we gave them.

Chairman STARK. That is exactly the point the Chair was making.

The committee will recess until 1 o'clock.

[Recess.]

Chairman STARK. The hearing will continue, and our next witness will be Alan Spielman, the executive director of Government Programs and Legislation for the Blue Cross/Blue Shield Association.

Welcome to the committee, Mr. Spielman. Your testimony will appear, without objection, in its entirety in the record, and you may proceed to summarize or elaborate on it in any way you are comfortable.

## STATEMENT OF ALAN P. SPIELMAN, EXECUTIVE DIRECTOR, GOVERNMENT PROGRAMS LEGISLATION, BLUE CROSS & BLUE SHIELD ASSOCIATION

Mr. SPIELMAN. Thank you, Mr. Chairman.

Chairman STARK. But be prepared to defend your numbers.

Mr. SPIELMAN. As always. We appreciate this opportunity to testify on the issues related to expanding Medicare to cover outpatient prescription drugs.

Our comments are based on our experience in administering Medicare as intermediaries and carriers, and based on our experience in designing and implementing prescription drug programs in the private market.

My written statement provides details on the drug coverage for the elderly provided by Blue Cross and Blue Shield programs.

While private insurance does provide prescription drug coverage for a significant proportion of the elderly, the fact remains that most beneficiaries are not covered. As you consider legislative proposals to expand Medicare in this area, we would urge you to consider carefully the benefit costs of the new program, the administrative issues involved, and the financing mechanisms for the new benefits. Including prescription drug coverage in insurance programs is expensive. The costs of drug benefits for the elderly is particularly expensive.

Increases in the price and volume of prescriptions will work to make the benefit costs of the Medicare drug program substantial. Moreover, the historical record of Medicare illustrates how difficult it is for anyone to predict accurately the cost of new benefits.

We would, therefore, urge you to assess carefully the estimates of future year benefit costs for this program, and to include measures designed to manage effectively both the amounts that Medicare will pay for each prescription and the utilization of drugs by beneficiaries.

With respect to program administration, we urge that efforts be made to make the program as simple as possible, and to provide the greatest incentives for billing by providers rather than by beneficiaries.

Provider billing, which often can be done electronically, can result in significant savings in the administrative costs of the program. Even with a substantial amount of electronic billing by providers, however, we would expect the administrative costs of the new program to be relatively high. Adequate funding and leadtimes will be critical to assure the success of any new program.

Finally, we believe strongly that the financing mechanism for major benefit expansions should not place undue burdens on those with low incomes.

We would now like to provide you with some specific comments on the proposal recently developed by the chairman.

The establishment of a $500 deductible is consistent with the concept of providing a catastrophic drug program. While this approach does limit benefit costs, it should be recognized that it will increase administrative costs relative to benefit payments because an eligibility tracking system must be developed, and judgments must be made on claims for which no payment is made.

If most pharmacies decide to participate in Medicare, the administrative costs of the deductible feature would be constrained somewhat. Based on our experience in administering Medicare, however, we would anticipate a great deal of confusion and a fairly long startup period before the program is at the point where the pharmacies themselves, rather than the Medicare carriers and HCFA, will be able to handle most of the administrative work for beneficiaries.

On balance, while the deductible feature is administratively cumbersome, we believe it is necessary to avoid excessive program costs.

Requiring beneficiaries to pay for part of the cost of each prescription is an approach commonly used in our private health benefit programs to help contain benefit costs. The use of a 20-percent coinsurance rather than a fixed dollar copayment would provide beneficiaries with an incentive to seek out lower priced drugs. It also would have the advantage of being consistent with the rest of part B cost-sharing.

The disadvantages of this approach, however, are threefold. First, those beneficiaries requiring the most expensive medications will be faced with the largest financial liability.

Second, coinsurance based on a percentage of the prescription charge could create an incentive for the ordering and filling of prescriptions in lower quantities.

Third, a percentage copayment would be more difficult for beneficiaries to understand and would increase administrative costs, particularly in the handling of inquiries and complaints.

For these reasons, we recommend use of a fixed-dollar copayment per prescription, such as $3 to $5 per prescription. If the subcommittee concludes that beneficiaries should bear some of the financial consequences of obtaining a more expensive brand-name drug when a lower cost substitute is available, a variable copayment could be considered, for example, $1 per generic prescription.

We do have some concerns about the reimbursement formula in the proposal. The proposed use of average wholesale price in the calculation of the payment limit could result in excessive benefit payments. The subcommittee may wish to explore using estimated acquisition cost data in this calculation.

We would note, however, that a key issue in this area is balancing cost containment with concerns about access, and the higher payment levels under an AWP approach would likely encourage higher levels of pharmacy participation.

We are also concerned about the level of the dispensing fee that is included in the payment limit. In our judgment, the $4.50 fee is too high. A $4 fee would likely fairly compensate pharmacies for their administrative activities in this area.

We would like to raise three additional issues for your consideration. First, the proposal appears to provide no explicit control over the costs of the first $500 of drugs that will trigger the catastrophic benefit. While administratively more costly, it would be advisable to subject these initial benefit costs to the payment limits applied to prescriptions after the deductible is met.

Second, to provide greater incentives for beneficiaries to seek out participating pharmacies, we would recommend that you consider establishing a lower payment level for drugs provided by non-participating pharmacies, such as 75 percent of the amount paid to the participating providers.

Third, while we have not had the opportunity to do our own estimate of the administrative costs of the proposal, we do believe they would be substantial.

For example, while the overall administrative costs of Medicare contractors now represent about 1.4 percent of program outlays, we could expect the administrative costs of this program to be on the order of 10 percent, or even more.

We would urge you to encourage that the necessary funds to prepare for startup of the new program be included in the fiscal year 1988 appropriation, and that funding for the ongoing administration of the bill be included in subsequent appropriations.

At this point we believe an effective date of January 1, 1989 is reasonable.

In conclusion, Mr. Chairman, we do appreciate this opportunity to provide the subcommittee with comments on proposals to expand Medicare to include outpatient prescription drugs.

This is an area where we would urge thoughtful attention to program design and to the administrative aspects of the program. We are convinced that HCFA and the Medicare carriers could make this program work effectively if adequate administrative funding and leadtime is provided, and we stand ready to assist you in any way we can in that effort. Thank you.

[The statement of Mr. Spielman follows:]

# STATEMENT OF ALAN P. SPIELMAN
EXECUTIVE DIRECTOR, GOVERNMENT PROGRAMS LEGISLATION
BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. Chairman and members of the subcommittee, I am Alan P. Spielman, Executive Director, Government Programs Legislation, of the Blue Cross and Blue Shield Association. We appreciate this opportunity to testify on the issues related to expanding Medicare to cover outpatient prescription drugs. The Blue Cross and Blue Shield Association and its member Plans have been major participants in the administration of Medicare since its beginning. Blue Cross and Blue Shield Plans also have developed and implemented outpatient prescription drug benefit programs in the private market.

The lack of Medicare coverage for outpatient prescription drugs does leave beneficiaries liable for significant expenses. Many, but certainly not most, beneficiaries are protected against major out-of-pocket costs for prescription drugs by private coverage which supplements Medicare benefits -- Medigap -- and through enrollment in health maintenance organizations (HMO's) or comprehensive medical plans (CMP's). In 1985, we estimate that 43 percent of Blue Cross and Blue Shield Plan non-group Medigap programs included coverage for prescription drugs. We expect that the percentage of retiree group plans covering prescription drugs is even higher. In addition, of the 45 Blue Cross and Blue Shield Plan health maintenance organization programs that participate in Medicare, 18 offer prescription drug coverage.

While private insurance does provide prescription drug coverage for a significant proportion of the elderly, the fact remains that most beneficiaries are not covered. According to AARP, almost 60 percent of Americans over age 65 lack insurance coverage for outpatient prescriptions.

As the subcommittee considers legislative proposals to expand Medicare to help pay for outpatient prescription drugs, we would urge you to consider the following issues:

- o Benefit Costs
- o Program Administration
- o Financing Mechanisms

## Benefit Costs

Including prescription drug coverage in insurance programs is expensive. The cost of drug benefits for the elderly is particularly expensive. For example, one large Blue Cross and Blue Shield Plan reports that the average number of prescriptions filled for retirees in its private health plans was almost three times as high as the average number of prescriptions filled for all enrollees. The average prescription cost for retirees in that area was about 22 percent higher per retiree prescription than the average prescription cost for all enrollees.

Data on the utilization and cost of drug benefit programs administered by Blue Cross and Blue Shield Plans in three large states further confirm the high cost of drug benefits for the elderly. These data show benefit payments for nearly 40 prescriptions per year for elderly subscribers filing claims at an average cost of $20 per prescription.

Increases in costs of drug coverage are driven by the high rate of inflation in drug prices, by increasing numbers of prescriptions per subscriber, and in many cases, adverse selection. When consumers have a choice of varying benefit options, they often will purchase a program that covers drugs if they anticipate greater than average expenditures for drugs. This phenomena raises the cost of the benefit programs.

While including outpatient prescription drugs as a covered benefit under Medicare for all beneficiaries should not result in any adverse selection, the other factors -- increases in the price and volume of prescriptions -- will work to make the benefit costs substantial. Moreover, the historical record of Medicare illustrates how difficult it is for anyone to predict accurately the cost of new benefits. We would, therefore, urge you to assess carefully the estimates of future year benefit costs for this program and to include measures designed to manage effectively the amounts that Medicare will pay for each prescription and the utilization of drugs by beneficiaries.

## Program Administration

In designing an outpatient prescription drug program under Medicare, the complexity and cost of program administration should be assessed carefully. As a guiding principle, all efforts should be made to make the program as simple as possible and to provide the greatest incentives for billing by providers rather than by beneficiaries. Provider billing, which often can be done electronically, can result in significant savings in the administrative costs of the program. In relation to benefit payments, the administrative costs of handling paper claims on prescription drugs can be very high because the billed charge per claim is generally small. Even with a substantial amount of electronic billing by providers, we would expect the administrative costs of implementing and administering a new drug program under Medicare to be high. Adequate funding and lead times will be critical to assure the success of any program that is enacted.

## Financing Mechanisms

As we indicated in our testimony before the subcommittee on the Medicare catastrophic bill, we believe strongly that the financing mechanism for major benefit expansions should not place undue burdens on those with low incomes. Since the benefit and administrative costs of a new drug program will likely be high, we would urge that it be financed through an income-related approach or through other financing sources that do not require contributions from beneficiaries with low incomes.

## Legislative Proposals

We would also like to provide the subcommittee with comments on the proposal recently developed by Chairman Stark and H.R. 2485, the bill introduced by Representative Waxman and others.

### Stark Proposal

This proposal would cover all outpatient prescription drugs with a $500 annual deductible, require a 20 percent coinsurance per prescription, establish payment limits based on the average wholesale price of the drug plus a $4.50 dispensing fee, authorize a drug formulary, and establish a participating pharmacy program. One-half of the cost of the new benefits would be financed by an increase in the Medicare Part B premium. The other half would be financed by an increase in the Medicare supplemental premium for catastrophic coverage included in H.R. 2470, the committee's Medicare catastrophic coverage bill.

The establishment of a $500 deductible is consistent with the concept of providing a catastrophic drug program. While this approach does limit benefit costs, it should be recognized that it will increase administrative costs relative to benefit payments because an eligibility tracking system must be developed and judgments must be made on each claim even though no payment is made.

If most pharmacies decided to participate in Medicare and perform the required administrative functions of accumulating beneficiary charges and billing carriers only after the deductible had been reached, the administrative costs of the deductible feature would be constrained somewhat. Based on our experience in administering Medicare, however, we would anticipate a great deal of confusion and a long start up period before the program is at the point where the pharmacies themselves, rather than the Medicare carriers and HCFA, will be able to handle most of the administrative work for beneficiaries prior to the point at which they meet the deductible. On balance, while the deductible feature is administratively cumbersome, we believe it is necessary to avoid excessive program costs.

Requiring beneficiaries to pay for part of the cost of each prescription is an approach commonly used in our private health benefit programs to help contain benefit costs. Beneficiary cost-sharing would likely have some effect in deterring unnecessary prescription filling. It would, of course, reduce program outlays by the cost-sharing amount. The use of a 20 percent coinsurance, rather than a fixed dollar copayment, would provide beneficiaries with an incentive to seek out lower-priced drugs. It also would have the advantage of being consistent with the beneficiary cost-sharing applicable to most other Part B services.

The disadvantages of a 20 percent coinsurance provision are three-fold. First, those beneficiaries requiring the most expensive medications will be faced with the largest financial liability. Lower income beneficiaries could be particularly disadvantaged under this approach. Second, coinsurance based on a percentage of the prescription charge would create an incentive for the ordering and filling of prescriptions in lower quantities. This would be particularly relevant for lower income beneficiaries who would likely prefer to spread the out-of-pocket costs of a prescription over several purchases when a small prescription is refilled rather than paying a large initial copayment. Third, a percentage copayment would be more difficult for beneficiaries to understand and would increase Medicare administrative costs, particularly in handling inquiries.

For these reasons, we recommend use of a fixed dollar copayment per prescription, such as $3.00 to $5.00 per prescription. While this approach would not provide explicit incentives for beneficiaries to choose lower priced products, it would be much simpler to understand and administer. Other features of the program, such as the reimbursement formula, could encourage the use of lower-priced products where appropriate. If the subcommittee concludes that beneficiaries should bear some of the financial consequences of obtaining a more expensive brand name drug when a lower cost substitute is available, a variable copayment could be considered. Under this approach beneficiaries would be responsible for a lower copayment when a generic prescription is filled, for example, $1.00 per prescription.

We do have some concerns about the reimbursement formula contained in the proposal. The proposed use of average wholesale price (AWP) in the calculation of a payment limit for drugs could result in excessive benefit payments. Based on our experience, we believe that average wholesale price does not accurately reflect the acquisition cost of most pharmacies. It is, however, a simple, widely-understood measure the use of which can avoid the more costly task of pharmacy financial audits. The subcommittee may wish to explore using estimated acquisition cost data in the payment limit calculation. Estimated acquisition cost amounts could be based on the cost of the most commonly purchased package size.

In determining the most appropriate basis for the reimbursement formula, a key issue is balancing cost containment with concerns about access. The higher payment levels under an AWP approach would likely encourage higher levels of pharmacy participation.

We are also concerned about the level of dispensing fee that is included in the payment limit. In our judgment, the $4.50 fee is too high. While a reasonable fee is needed to compensate pharmacies both for their normal administrative overhead and for the increased costs they would incur in helping Medicare beneficiaries with their claims, a $4.00 fee would likely accomplish this objective.

We support providing the authority for HHS to develop a drug formulary, although we believe that a formulary should not be required. Conceptually, a drug formulary may be appropriate. However, beneficiaries and providers may not understand it, resulting in a high number of inquiries and a high level of dissatisfaction with the new program. The policy and operational issues relating to the establishment of a drug formulary for Medicare reimbursement purposes should be explored thoroughly before a decision is made to move forward.

Regarding the financing mechanism included in the proposal, we would recommend a change so that the new benefits are fully financed by the Medicare supplemental premium for catastrophic coverage. General revenue financing sources could also be considered to help finance the new benefits. Financing even a part of an expensive new benefit through the regular Part B premium charged to all enrollees could result in an excessive burden on beneficiaries with low incomes.

We would like to raise three additional issues for your consideration concerning this proposal. First, the proposal appears to provide no explicit control over the cost of the first $500 of drugs that will trigger the catastrophic benefit. The lack of control could encourage excessive prices for beneficiaries who are likely to reach the $500 threshold sometime during the year. At a minimum, it could trigger catastrophic benefits based on drug prices that are higher than the Medicare payment allowance. While administratively costly, it would be advisable to subject the first $500 in drug expenses to the same payment limits applied to prescriptions billed after the deductible is met.

Second, to provide greater incentives for beneficiaries to seek out participating pharmacies we would recommend that you consider establishing a lower payment level for drugs provided by nonparticipating pharmacies, such as 75 percent of the amount paid to participating pharmacies. This approach is used by Blue Cross and Blue Shield of Michigan in its private market prescription drug programs. It should be noted that 98 percent of pharmacies in Michigan participate in these programs.

Third, while we have not had the opportunity to do our own estimate of the administrative costs of the proposal, we do believe they would be substantial. The capacity will have to be developed to sign-up participating pharmacies, to process both provider claims and unassigned hard copy claims filed by beneficiaries, to determine whether the $500 is met, to establish an inquiry capability, to conduct pharmacy audits, to handle beneficiary and provider appeals, and to handle other administrative tasks. A major effort to educate physicians, pharmacies, and beneficiaries about the new program will also have to be undertaken.

In relationship to benefits paid, the startup and ongoing administrative costs are likely to be very high. For example, while the overall administrative costs of Medicare contractors now represent about 1.4 percent of program outlays, we expect that the administrative costs of a new pharmacy program would be in excess of 10 percent of the benefit costs. An increase of 30 to 40 percent in the overall Medicare contractor budget, which is now $1.1 billion, would not be unreasonable. In fact, the cost may be much higher. We are, however, convinced that HCFA and the Medicare carriers could make this program work if adequate administrative funding and lead time is provided. We would, therefore, urge you to encourage that the necessary funds to prepare for program implementation be included in the FY 1988 Labor/HHS appropriations bill. Adequate funds for ongoing administration of the program should be included in the appropriations for FY 1989 and later years. At this point, an effective date of January 1, 1989 appears reasonable. We would be pleased to work with the subcommittee to develop more specific estimates of the administrative tasks and costs involved.

## H.R. 2485

This bill is similar to Chairman Stark's proposal except that no coinsurance would be required and no drug formulary would be authorized. In addition, it would be fully financed by an increase in the Part B premium assessed on all Part B enrollees.

Many of the issues we raised in connection with Chairman Stark's proposal are equally applicable to H.R. 2485. Because we are concerned about the effects of higher premiums on those with low incomes, we recommend against the financing mechanism included in H.R. 2485. While current estimates project a relatively modest increase in the Part B premium of $5.00 per month in 1989, even this amount may be unaffordable to many beneficiaries. In addition, for the reasons mentioned earlier, it is likely that the true benefit costs may well exceed these estimates because of factors that are difficult to predict.

We also recommend against the provision in H.R. 2485 relating to regional carriers for administration of the new benefit. Such a provision is unnecessary since HCFA already has the authority under current law to establish regional carriers for handling certain types of Part B claims. It also should be noted that a regional approach to the administration of this benefit may not be in the best interest of the program or its beneficiaries. The need for beneficiary and provider communication and familiarity with the local environment will, in our view, be critical to the success of this new program. We would recommend that the program be administered through the existing carrier structure.

## Conclusion

The Blue Cross and Blue Shield Association appreciates this opportunity to provide the subcommittee with comments on proposals to expand Medicare to include outpatient prescription drugs. This is an area where we would urge thoughtful attention to program design and to the administrative aspects of the program. We stand ready to assist the subcommittee in any way we can to analyze these proposals further.

906:6/1/87

Chairman **Stark**. Thank you very much. We have a vote. Would you like to inquire, and I will go vote? Is that all right with you, Mr. Levin? I will go vote and come back, so we will just keep going.

Mr. **Levin**. Seriatim.

Mr. **Gradison**. Well, perhaps I could begin, then, with some questions. Do some of the Blue Cross and Blue Shield associations today offer an outpatient prescription drug benefit?

Mr. **Spielman**. Yes. With respect to the elderly, we estimate about 43 percent of the so-called Medigap programs include such coverage. A significant portion of the HMO programs cover it, and of course for the under 65 population it is fairly widespread, although I do not have the statistics on that.

Mr. **Gradison**. Could you advise us what the characteristics of these programs are with regard to coverage, formulary, deductibles, copayments, indexing, and some of the other issues which have been discussed here.

Mr. **Spielman**. Basically they fall into two categories, either a freestanding program where a per prescription copayment—$3 or $3.50, for example, is applied to the cost of the drug, or incorporated into a major medical program, where, in addition to the cost of physician office visits, the cost of drugs are included in calculating the deductible initial amount. Once that is met, then a 20-percent copayment is applied.

Ideally, you would want to consider a freestanding program because in such a program you have better control over payment levels. In addition the administrative costs are less because you can increase your volume of provider claims.

In fact the witness from Michigan Blue Cross and Blue Shield testified last month that their programs have a participation rate of 98 percent of the pharmacies. When you go to a major medical approach, you are talking about subscriber-filed claims which are more expensive to process.

The copayment features tend to be on the order of $3 to a $5. I think there are some plans that are considering and have implemented a variable copayment based, as I suggested in my testimony, on whether or not a generic prescription is provided.

There is one example of a $1 copayment, if a generic is provided, and a $5 copayment for other drugs, but generally there tends to be a flat copayment when they are freestanding programs.

The deductibles tend to be a function of the overall deductible on major medical. If I would just cite the Federal employees health benefit programs, it is on the order of $200 to $250, but that includes expenses other than drugs.

Mr. **Gradison**. We are working on the drug issue in connection with the catastrophic bill. Would you advise us, based upon your experience, to include the deductible as you do with some of your major medical plans, and then an overall deductible cap rather than have a separate cap for drugs?

Mr. **Spielman**. That is a difficult question because you are balancing, some concerns about equity here with administrative complication. The bill before you does have the anomaly that someone could have catastrophic part B expenditures but not have catastrophic drug expenditures, and that will likely result in some confusion, and obviously inquiries, and resulting administrative costs.

On the other hand, given the structure of the bill, which is to place the burden on the pharmacies to accumulate the drug charges until the threshold is met, it would be very difficult to integrate the two.

So my opinion would be, assuming you are going with this approach where the carrier ideally would not see the claim until the threshold was met, that you are probably better off separating them.

Mr. **Gradison**. You had mentioned in your testimony—as I understood it—a preference for the flat $3 copayment rather than a percentage coinsurance, but you also have mentioned that Blue Cross plans are of both varieties.

Mr. **Spielman**. Yes.

Mr. **Gradison**. Why don't they all take the fixed dollar approach, if that is the preferable way to go?

Mr. **Spielman**. Well, because where they are not fixed dollar copayments, it tends to be because of the benefit structure of the overall major medical plan. For example, a 20 percent coinsurance on outpatient drugs, physical therapy, outpatient physician visits combined. Outpatient drugs are not a separate component of the benefit plan.

And again, a coinsurance approach can work. However, when you are talking about the elderly population with some of these maintenance drugs costing a lot, and where your opportunity to shop is relatively limited—you do face the possibility of extensive out-of-pocket liability on individual claims.

So it is not a clearcut issue and you do make a trade off going to the dollar copayment. On balance, we sided with GAO to say that for simplicity's sake, it might be more effective to use a copayment.

Mr. **Gradison**. I think we may have to take a break here so that we can all vote. We only have a limited time remaining.

[Brief recess.]

Chairman **Stark**. We will continue. What steps, Mr. Spielman, would you recommend to keep administrative costs as low as possible under a Medicare drug benefit?

Mr. **Spielman**. Well, one of them that we mentioned in our written testimony is to provide some greater incentives for participation through a lower payment amount for the nonparticipating pharmacies. The thing we need to avoid is a large volume of beneficiary-filed claims because they are expensive to process.

I believe that a concerted effort to educate providers, beneficiaries, and physicians about the scope of the new benefit will also have to be undertaken.

There are certain aspects of the benefit that will be confusing to individuals. As I mentioned earlier, for example someone might trigger the catastrophic acute-care benefit, yet not trigger the catastrophic drug program.

That may be a necessary part of administering these two programs but it will be confusing to people. So I would recommend a concerted effort to educate people about it, and I would again urge a flat dollar copayment rather than a percentage coinsurance, and——

Chairman **Stark**. That, on an administrative basis as well as just on a, being less costly to the beneficiary?

Mr. SPIELMAN. Yes. Anything that simplifies the program will likely help to keep administrative costs down. A lot of the inquiries we get right now, and I would note that our inquiries on part B in general, are at their highest rate ever—relate to confusion over the reasonable charge formula and the application of the $75 deductible. So it is confusing. I believe that if you knew that it was $4 or $5 a pop for a prescription it would simplify matters.

Chairman STARK. Are there any particular measures that you use, that Blue Cross or Blue Shield plans use, that we have not touched on here, that you would commend to the committee?

Mr. SPIELMAN. Well, although I mentioned it just generally in the statement, the private market is increasingly looking to the whole area of utilization review programs. There is not a lot of experience with it, but we do have some programs operating where screens are established to identify aberrant prescription practices and——

Chairman STARK. Who is this? Reviewing the physicians?

Mr. SPIELMAN. Well, it really would be reviewing the profiles of individuals. I mean, it can include identifying an abusive situation where an individual is getting the same prescription filled six times and providing the drugs to a relative. This is a very rare instance, but it is the kind of thing you can uncover with a drug-utilization review monitoring program.

The more likely thing is that you find people taking a lot more prescriptions, many of which can be contraindicated. Just looking at that volume and getting that report back to the physician can, just through the educational process, result in a better quality of care, and it also can constrain program dollars.

Chairman STARK. This is not then directed at the physician, necessarily, but at the beneficiary.

Mr. SPIELMAN. Yes, but the intent is, not to deny a claim when a beneficiary has obtained a lot of prescriptions without any evidence of abuse.

It is directed to the physicians as far as education goes, and on occasion we will work with the pharmacies as well.

Chairman STARK. Aren't there some pharmacies that do that now, some of the chains? Don't they keep computer records of all their customers?

Mr. SPIELMAN. Well, yes. Yes. I think that is a very common practice.

Chairman STARK. Is it common among the larger pharmacies?

Mr. SPIELMAN. Based on the advice I have received, I believe the answer is yes. However, that does not obviate the need for the Medicare program to have its own monitoring program.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Thank you. Your testimony is thoughtful, indeed. Let me just be sure I know where you are with your various caveats. You believe we should act favorably in this area this year?

Mr. SPIELMAN. Well, Mr. Levin, I believe the question is whether or not, as a matter of policy, you decide that the costs of the bill are worth the benefits it would provide.

Mr. LEVIN. Tell us from your experience whether you think it would be.

Mr. SPIELMAN. Well, from our experience, we know that it is expensive. When one compares that to the need that is presented before you, I believe there is a value judgment that our experience cannot provide the answer to.

One must consider the value of this benefit to the beneficiaries. As I pointed out in my testimony, there is a significant proportion, but certainly not the majority of people, that do get this coverage in the private market already.

As I indicated in my written statement 43 percent of our medigap products include some sort of prescription drug programs. We also know there are some special State programs for the low-income elderly as well as the regular Medicaid programs.

So I cannot give you a definitive answer to whether or not you should proceed. We have not, for example, had an opportunity to look at the estimates of costs that are before you and I believe it is a decision for the Congress to make, whether or not those costs are worth the benefit.

There clearly are a lot of people that would benefit substantially by the inclusion of a Medicare drug benefit program. There is no question about that.

Mr. LEVIN. Well, drawing on your own experience, or experiences, it is a program that you think can be administered effectively?

Mr. SPIELMAN. Yes, and I believe the key issue there is a reasonably early time of enactment so we have time to develop the mechanisms to implement it, plus providing an administrative funding source that is sufficient.

Just as a general matter, we, it seems annually, have to recommend to the Congress increases in the administration's funding request for the administration of the Medicare program, and we would like, obviously, that not to happen here.

For example, in 1988, we do not expect that in part B, in general, the contractors will be able to meet the prompt payment standards set in OBRA based at the recommended funding level that is before the Appropriations Committee right now.

Mr. LEVIN. But based on your experiences, you think that costs can be contained?

Mr. SPIELMAN. Yes. And I do have some specific recommendations to help improve our capacity to do that.

Mr. LEVIN. Okay. So taking into account your suggestions, you do not believe that we are creating a nightmare in terms of unanticipated costs to the Treasury or to the program, whoever pays for it?

Mr. SPIELMAN. Well, I would not say that, and I would not say a nightmare. In the private market our experience is that these benefits always seem to cost more than we expect them to cost. In your own State of Michigan, from 1980 to 1986, the Blue Cross and Blue Shield plan saw a threefold increase in their drug expenditures. From 1985 to 1986 alone, they saw costs go up 21 percent.

It is likely that costs of a Medicare drug program will increase beyond what anybody can estimate right now. But again, back to your earlier question, that is a value judgment as to whether or not the Medicare program should be expanded to cover outpatient drugs or not.

Mr. LEVIN. And the costs, in your experience, have been greater than anticipated because you have not been able to control them, or because of need? I mean, just give us some idea of what the dynamics of unanticipated costs have been.

Mr. SPIELMAN. Well, first, there is a phenomena that happens in the private market that will likely not happen in Medicare, and that is adverse selection.

When people have a choice of benefit programs, if they anticipate a need of $500 a month in drugs, then they are likely to choose the health insurance plan that covers drugs. This adverse selection effect tends to increase the cost far beyond just the rate of inflation and the normal volume of prescriptions.

The price inflation in drugs has been significant. My recollection is, in the recent period, we have seen price inflation on the order of 8 to 10 percent in prescription drug prices when general inflation was running about 1.5 to 3 percent. We have also seen increases in the utilization of prescription drugs by covered individuals, and that has been the impetus for the development of some of these additional programs such as drug utilization review.

So we have not done as good a job as we could in containing costs. We are, however, looking for new techniques to do so, and I would expect, as Medicare carriers, we would be able to try to borrow from some of those techniques, and see what works well, and see what we could recommend to HCFA that they implement under Medicare.

Mr. LEVIN. But you think on balance, it is, in terms of cost containment, manageable?

Mr. SPIELMAN. Yes. It is expensive but it is manageable.

Mr. LEVIN. Thank you.

Chairman STARK. Mr. Moody.

Mr. MOODY. Thank you. I was not here for your presentation. I am sorry. I was at another event I had to go to. But glancing over your thoughtful and helpful presentation, just on the data side, you say that the data show that benefit payments for nearly 40 prescriptions per year for an elderly subscriber is filling claims at an average cost of $20 per prescription. That is $800 a year, right?

Mr. SPIELMAN. Yes.

Mr. MOODY. I see numbers in here that I think are quite a bit lower than that. It is interesting. Is that $800 a pretty firm figure?

Mr. SPIELMAN. Well, that is experience based on our private market programs, and as I mentioned to Mr. Levin, there could be an adverse selection phenomena in there. That is, to the extent there are some individual choice policies in there, individuals expecting a great-than-average need for drugs may have selected those programs. We have not done a study of that. That is based on a very "quick and dirty" run of the data that one of our plans had accumulated.

Mr. MOODY. The elderly that are involved in this computation would not typically have choices as to which plan they would select? Would some have drugs covered and some not?

Mr. SPIELMAN. Well, it is possible that much of the data from that reflects group retiree programs.

Mr. MOODY. That is my point. So there would not be that much adverse selection, scope, would there be?

Mr. SPIELMAN. No, but in other States, for example, in Massachusetts, where the drug program is part of a Medex program, like a Medigap program, it would.

Mr. MOODY. It would there?

Mr. SPIELMAN. Yes. And I cannot disaggregate those for you right now.

Mr. MOODY. Maybe later you could send us it, just broken out.

Mr. SPIELMAN. We will look at that and see if we can do that. We just simply did not have the time to do an extensive analysis here.

[The following was subsequently received:]

Disaggregating the data to eliminate all experience from individual choice policies, our data from a large State show an average number of 19.5 prescriptions per retiree in group plans at an average cost of about $19.50 each in 1986.

Mr. MOODY. Thank you. You recommend, as I understand—because I was not here—a copayment rather than a coinsurance approach. That is, a flat fee, some $3, or some other number, as opposed to a percentage of the cost. I do not know if you were here earlier, but I asked Mr. Zimmerman and Mr. Dowdal if in fact we wanted to have a continuous incentive for containing costs, that a percentage seems a lot better than a flat number. Once you are over the number, no one—you, your doctor, or the druggist—has any further incentive to hold down the size of the order, or the cost.

You do not think that a percentage is more cost containing than a flat copayment?

Mr. SPIELMAN. Well, no, because as I understand the bill, the program would pay the same amount for a single source drug, regardless of what the charge would be. So if a beneficiary had to choose between two pharmacies, one which charged twice the amount for the same drug than another, the Medicare payment would be the same regardless of where the drug was obtained.

Mr. MOODY. Well, it depends on whatever else you have. But just choosing between a percentage copayment and a flat copayment, it seems to me, regardless of whether, if you have a ceiling on drugs, or generic use, or other things you might add, yes, you might limit them anyway, so it washes out.

But if those other restraints are somehow not in place, or not effective, it seems to me a percentage is a better way of holding down costs.

Mr. SPIELMAN. Well, we did identify one option in that regard that you might consider, that has the same advantages of both approaches. Under this option, you have a variable dollar copayment.

For example, you could have a $5 copayment for all drugs, but where there is a multiple source product available, have a $1 copayment on the generic products. That could get at the problem that you are addressing.

It does, however, introduce a complication in the program. We are not recommending it for that reason——

Mr. MOODY. It would be administratively more complex, wouldn't it, because sometimes drugs, at one point, will have only one single source, and later on, there might be multiple sources.

Mr. SPIELMAN. Well, but that is relatively straightforward. I believe that this approach could be implemented, and in fact we do implement programs like this in the private market.

You have to remember that a coinsurance is administratively complex, too, because people do not understand it, and as the GAO mentioned, it requires a second billing on behalf of the pharmacy. A pharmacy will not really know what the 20 percent will be until it gets its payment back from Medicare.

Mr. MOODY. Maybe I am missing something, but could you not have a system of payment where the Medicare recipient comes to the counter and gets a $12 prescription, and let's say he is only liable for 20 percent, and he puts $2.40 on the counter, and he gets his prescription, and the pharmacy bills Medicare for the balance.

Why does it require two steps?

Mr. SPIELMAN. Well, I if you did it just like that, you would run into the potential of paying the pharmacist more than the cost of the drug, because the Medicare program is only going to pay the average wholesale price plus a dispensing fee.

So to the extent that that payment limit is lower than the $12 charge—in your example, let's say it is $6, it is half that amount—the Medicare program would pay six. And so if you based your coinsurance on the actual charge, if you added up the beneficiary coinsurance, plus the Medicare payment at 80 percent, the amount would be higher than the Medicare payment allowance.

So I would recommend against that approach.

Mr. MOODY. But could not the pharmacy keep a table on the counter, or behind the counter, which showed what the Medicare-eligible, amount for each of those would be, and so they would just charge 20 percent of that and the beneficiary puts that on the counter? Maybe it would be $1.80 instead of 2.40, and they would bill Medicare for the rest.

Mr. SPIELMAN. Well, that would be possible, and given the fact that Medicare will pay the same amount at any of a number of pharmacies for that same drug, that is not very different from what I am suggesting, and——

Mr. MOODY. Well, but not for the drug but for the quantity. I mean, how many pills you take home with you should be continuously economically relevant to the recipient, and not irrelevant once he gets past the threshold.

Mr. SPIELMAN. Well, that is a difficult area because you are balancing a less than optimum prescription size with a greater than optimum prescription size. If you go to a coinsurance approach you run the risk that to spread the copayment cost out, people will prefer to get a lot of small prescriptions as opposed to one that fully meets their drug regimen needs, which you would encourage under the $3 copayment approach.

In other words, it would be easier to pay 20 percent of a $12 prescription three times than to pay it in one shot early on. You are balancing out the economies of scale that happen when a prescription is filled at a reasonable number of units versus a larger quantity which runs into the problem of stockpiling.

The committee's bill does have a limit of a 60-day supply to minimize unnecessary units being prescribed.

Mr. MOODY. What if you only need a 30-day supply?

**Mr. Spielman.** Pardon?

**Mr. Moody.** What if a 30-day supply is all that you probably will need but you may need 60, but you will say, well, let's go ahead and get 60 days because I may need it, I may have to come back. On the other hand, you may not.

I am not talking about a maintenance that you have to stay on the rest of your life. I mean something the doctors prescribe because you are ill right now and hopefully will get better.

You would say, well, give me the 60 days. Why not? It is $3 anyway. Give me 60 days. And you end up throwing half the pills away later on.

**Mr. Spielman.** Yes.

**Mr. Moody.** I know that my medicine cabinet is stocked with pills that I never finish consuming. Every now and then I will throw them out. But there is a temptation to say—they are free, or at low cost—give me more. Who knows when I might need them again?

**Mr. Spielman.** I mean, there is no question that a coinsurance approach would provide an incentive for a lower priced product. My suggestion is that the dollar copayment, first, is simpler, and second could be modified to at least introduce some of those same incentives, although not to the same extent as you are discussing.

**Mr. Moody.** I have no further questions at the moment. Thank you. Mr. Chairman, maybe we could submit some questions in writing later as other things occur to us.

Chairman **Stark.** Without objection, I am sure that Mr. Spielman would be glad to respond.

Do you have both payments in your plans? I mean, the percentage and a flat dollar fee.

**Mr. Spielman.** Yes. It is driven primarily what the customers buy.

Chairman **Stark.** So you have experience with both?

**Mr. Spielman.** Yes.

Chairman **Stark.** And it is a clearcut favorite for you to go to the flat dollar fee? There is some difference in the subcommittee.

**Mr. Spielman.** It is not black and white and I will point out that in Michigan, for example, the plan has operated a program with a $3.50 cost-sharing for quite a while, and is now exploring the option of going to a percentage copayment.

Chairman **Stark.** Now, what is pushing them to do that? Why are they exploring this option?

**Mr. Spielman.** Well, I believe that some of the points that Mr. Moody made is driving it. On balance, it was our view that particularly for the elderly population, where you are dealing with what may be very high dollar expenses for a particular type of drug therapy that the individual has no control over, you are going to get a disproportionate out-of-pocket liability, and that may be significant for those with low incomes.

That concern tipped the balance for us, plus the administrative simplicity. It is more complex to go to a coinsurance. There may be a little bit of savings. I believe that the other recommendations we made here, you could constrain the benefit costs of the program in a way to make a more simpler copayment sufficient, and you could also explore other alternatives to your reimbursement formula as well.

Chairman STARK. You have plans in States that have formularies and States that do not have formularies. Any significant difference in costs?

Mr. SPIELMAN. We have not studied that, and we were supportive of the provision in the bill to give the authority for a formulary. I believe it is important that HHS study it carefully before going forward. There may be some unique circumstances in this population that warrant a deliberative approach.

Chairman STARK. But you see nothing wrong with starting without it, as long as they have authority to add it if it becomes necessary?

Mr. SPIELMAN. No, not at all, and in fact, with the reimbursement mechanisms for multiple source drugs, you might conclude that it may be an unnecessary complication, if that works well.

Chairman STARK. I think it would make a lot of people very happy if it were unnecessary.

Mr. SPIELMAN. Yes.

Mr. MOODY. Mr. Chairman, I have another question if the chairman will indulge it.

Chairman STARK. Sure.

Mr. MOODY. We have had some talk on this committee about apparently high possible costs of administering the pharmaceutical plus as opposed to other forms of Medicare benefits.

What is your organization's experience with the administrative cost of this versus other forms of health-care insurance?

Mr. SPIELMAN. This gets back to this two different types of benefit programs. If you are talking about a freestanding program that essentially works automatically with very little human hands touching it in terms of subscribers filing their claims, then you are talking about administrative costs that can be kept to a minimum because you are dealing with a lot of electronic transfer of claims.

In the major medical programs, it is higher on a relative basis because you have a lot of claims for which no payment is made, and your pricing and claims processing is more difficult because you are often dealing with the claims accumulated in a shoebox. We do not have firm national estimates on what the administrative costs might be. I believe based on the advice and counsel of the people that are closest to this, that you are talking probably on the order of 5 percent for a freestanding program, and probably on the order of 10 percent, or so, for a major medical program, but that is just an educated guess for you.

Mr. MOODY. Well, if this were administered separately, parallel but separate to the catastrophic bill that we are considering—for example—we are not integrating the deductibles, and so forth—it sounds to me like we are considering treating it as a fairly independent program.

Would you estimate, then, that 10 percent would be what we might expect to see as adminstration costs?

Mr. SPIELMAN. That is the benchmark that we included in our testimony, but I would caution that we have not had the opportunity to do our own administrative cost estimate of the Medicare drug proposal.

There are a lot of things that have to be done for Medicare that may not have to be done in a group-benefit program, where you have the employer who can educate the subscribers, and you have other advantages.

So it is very difficult to give a precise answer. If time permits, we would like an opportunity to look at it further, and perhaps comment on the CBO estimate.

Mr. Moody. Right. I would appreciate hearing from you later.

[The following was subsequently received:]

### Blue Cross & Blue Shield Association Comments on CBO Cost Estimates to Administer an Outpatient Prescription Drug Program

Our major concern with CBO's estimate of the costs necessary to administer a new Medicare drug program is the unit cost estimate.

CBO estimates it will cost about $1.25 to process a drug claim on average, about one-third the cost of other part B bills. Moreover, CBO projects that about half of all claims will be submitted electronically.

We believe that because of all the tasks needed to be done in administering a new drug benefit, it initially will cost the same amount to process a drug bill as it will cost to process other part B bills—about $1.90 per claim in 1989 based on our estimates. After the program has been operational for some time and as more claims are submitted electronically, it may be possible to process prescription drug bills at lower costs.

These tasks include signing up participating pharmacies, processing both provider claims and unassigned hard copy claims filed by beneficiaries, determining whether a deductible is met, establishing an inquiry capability, handling beneficiary and provider appeals, developing provider and beneficiary profiles to detect and prevent abusive practices, and handling other administrative tasks. A major effort to educate physicians, pharmacies, and beneficiaries about the new program will also have to be undertaken.

We would also like to mention that if the volume of claims increases above CBO estimates, as envisioned by the administration, additional administrative resources would be necessary.

Mr. Moody. It sounds to me, though, from what you say, that for Medicare it might be more than a comparable program in the private sector. In other words, it might range up from 10 percent than down below 10 percent?

Mr. Spielman. Yes. Just to give you an example, under Medicare, we issue an explanation of Medicare benefits on every claim form, but in some of the private market programs, we can batch those in ways. Many of these things I am sure could be explored and introduced in the Medicare to result in additional efficiencies, but early on, I believe you are going to look at relatively high administrative costs. We would like to think that there will be a learning curve for all parties and that costs would drop down further over time.

But it is going to be high relative to our average of 1.4 percent which we are doing now as carriers and intermediaries.

Mr. Moody. Thank you.

Chairman Stark. Thank you, Mr. Spielman, very much.

Our next panel will consist of Maude Babington, director of professional affairs, American Pharmaceutical Association; John Rector, general counsel and vice president for Government affairs, National Association of Retail Druggists; Patrick Donoho, director of Government affairs, Revco, Inc., representing the National Association of Chain Drug Stores; and Robert Allnutt, executive vice president of the Pharmaceutical Manufacturer's Association.

Mr. LEVIN. Mr. Chairman—while everyone is being assembled—I need to go to a meeting. I did not figure that we would be working this long. So, if you would excuse me, I have to kind of semichair a little informal meeting regarding the State of Michigan. So I will leave and I will try to get back.

Chairman STARK. Next to the United States and California and Wisconsin, I can think of nothing more important.

Mr. LEVIN. I knew you would put it in that order, Mr. Chairman. Could I just ask one question as I go, if I might, of the representative of the Pharmaceutical Manufacturer's Association?

Chairman STARK. Go ahead.

Mr. LEVIN. As I have been looking over the testimony, is there unanimity within your association on your statement?

Mr. ALLNUTT. As far as I know, Mr. Levin. The board considered this general subject at a meeting in May and there were no dissenting votes to the position taken by the board, so my short answer is yes, as far as I know.

Mr. LEVIN. I hope to get back to ask some further questions, and my apologies for having to leave for at least 40 minutes. I hope you will have many questions, and there may even be a vote in the meanwhile.

Thank you.

Chairman STARK. The gentleman is excused.

First of all, without objection your prepared testimony will be made a part of the record. If you would like to proceed to summarize or expand on your testimony in any manner you desire, we will just have you go in the order you were called up. Do you want to proceed, Ms. Babington?

## STATEMENT OF MAUDE A. BABINGTON, DIRECTOR OF PROFESSIONAL AFFAIRS, AMERICAN PHARMACEUTICAL ASSOCIATION

Ms. BABINGTON. Thank you and good afternoon. My name is Maude Babington. I am a pharmacist with the American Pharmaceutical Association [APhA]. We are the national professional society of pharmacists.

I am here today to testify in support of this legislative outline and I would just like to briefly mention four points that are certainly covered in more detail in our written testimony.

First of all, we feel that there is a need for this proposed legislation to work in concert with existing State laws. For example, this proposed legislation authorizes the Secretary to develop a national formulary. APhA is opposed to the use of a national formulary because we feel that such a formulary would be cumbersome to develop, difficult to continually revise, update, and distribute to the participating pharmacies throughout the country.

As a result of this we think that this formulary might create delays in the availability of new therapeutic agents to the participants in this program. And finally, we think that a national formulary might come into conflict with some other existing formularies. In particular, I am talking about the State formularies that are described by the drug production selection laws that exist in the 50 States.

Within these laws we think there are some inconsistencies that may arise concerning what constitutes a multiple source drug for purposes of reimbursement under this legislation as proposed. APhA recognizes and endorses the desire of Congress to contain costs through the use of a formulary. However, we believe that the current efficiency of State drug product selection laws will accomplish this goal.

Another issue that is relevant to State laws is APhA's support for the inclusion of a limit on the supply of medication dispensed at any one time, as has been proposed in this bill. However, APhA believes that the limit should be set at a 30-day supply of medication, as is the case in some State laws.

We believe this because a 30-day limit will cause the patient to come into contact with the pharmacist more often. That contact will increase the vigilance of both the pharmacist and the patient. Therefore, the patient's compliance should be improved, and therefore the effectiveness of that drug therapy should be improved. And overall, cost effectiveness of the therapy would be increased.

Our second issue concerns certain aspects of the proposed reimbursement mechanism. Since the market for prescription medications and pharmaceutical services is already a highly competitive one, our position is that marketplace pricing with percentile screens that would guarantee reasonable prices should be the reimbursement system that is used whenever possible.

We would be pleased to work with the committee to help show you how such a system might be implemented. At this time, however, we are prepared to support the use of a national average wholesale price plus regularly updated fees for computation of reimbursement rates the way it is described in the proposed legislation.

However, I have to say that we do have serious concerns about how such a system might actually be implemented because of our experience in the Medicaid program. Medicaid reimbursement, which does use a cost plus fee approach has over time produced reimbursement levels that are totally inadequate for the services that pharmacists provide.

Thus, we believe that if this suggested mechanism is used, that the fee absolutely must be updated annually to ensure adequate compensation. Likewise, we would urge that the readily available monthly wholesale price updates be recognized as necessary because when a manufacturer increases the price of a drug, the impact on the pharmacist is immediate.

We get that information right away, and therefore we have to pay that increased price. We do not feel that pharmacists should be forced to absorb that price and in effect subsidize the program over an extended period of time.

The bottom line is, there are a lot of ways you can do this. We have been talking about it all day. What is important to us as pharmacists is that the system be fair, that it provide adequate reimbursement, and that it be current, constantly updated, current to what is applicable today to what the pharmacist is having to pay.

Regarding the issue of proposed coinsurance. APhA believes that the proposed legislation should be consistent with the philosophy that describes catastrophic medical expenses which places a cap on potential monetary losses.

If the philosophy underlying the bill is to ensure that no Medicare beneficiary has to pay out of pocket more than some predetermined amount of money, then a coinsurance provision that is applicable only to prescription medications seems to be inappropriate. We would therefore urge the committee to eliminate the coinsurance provision from the proposed bill.

Finally, regarding a procedural aspect, we are very pleased to see the reference to electronic claims processing and we would certainly support such a development. However, in the interim, until this is brought into effect in 1991, we would urge the use of the universal third party claim form.

This is a paper and pen form that is used in virtually every pharmacy in the country. It can also be processed on software systems, but we feel it would substantially enhance the acceptability and efficiency of this program.

In summary, on behalf of APhA we are in support of this bill, basically as outlined, with the changes that we recommend, and we would look forward to working with the Committee further on this issue.

Thank you.

[The statement of Ms. Babington follows:]

## STATEMENT OF MAUDE A. BABINGTON, AMERICAN PHARMACEUTICAL ASSOCIATION

My name is Maude A. Babington. I am a pharmacist and Director of Professional Affairs for the American Pharmaceutical Association (APhA), the national professional society of pharmacists. I am here today to testify in support of the proposed bill which would provide for coverage of prescription drug expenses for the elderly. I would like to thank you for allowing APhA to present its views on the necessity for and the structure of Medicare Part B coverage for catastrophic expenses for prescription drugs.

APhA has long recognized the need for insurance coverage of pharmaceutical products and services. In fact, just this past March, APhA's House of Delegates approved two policies that state:

> APhA supports comprehensive catastrophic illness insurance coverage that recognizes the essential need for pharmaceutical products and services in all patient care environments, including the home; and
>
> APhA encourages inclusion of pharmaceutical services, the most efficient and readily accessible system of drug delivery, in any insurance coverage for catastrophic illness that may be enacted.

APhA believes that any insurance program for catastrophic illnesses should include coverage for prescription drugs and pharmaceutical services. For three out of four elderly Americans, prescription drugs represent their largest out-of-pocket health care expense. A 1986 study commissioned by the American Association of Retired Persons (AARP) projected drug expenditures for those persons 65 years of age and over to be $9 billion, of which $7.3 billion were estimated to be out-of-pocket. This serious lack of coverage for pharmaceutical products and services is surprising when you consider that drug therapy has been shown to significantly reduce the overall cost of care. The treatment of ulcers and tuberculosis represents just two examples of how effective drug therapy can dramatically reduce the total costs of treatment. APhA believes that coverage for outpatient pharmaceutical products and services through Medicare will contribute to greater cost effectiveness in overall health care delivery.

Thus we are pleased to see this Committee take a major step toward this end by proposing a mechanism for Medicare Part B coverage of catastrophic prescription drug expenses that utilizes the highly competitive and efficient drug delivery system currently in place.

The remainder of my comments will focus on three basic issues. First, I will briefly address the important role that pharmacists currently play in patient care and how that fits into the system proposed by this bill. Second, I will describe how this bill should work in concert with current state laws. Third, I will address certain aspects of the proposed reimbursement mechanism.

First, I want to note how pleased we are that Rep. Stark and the co-sponsors of this bill have recognized the central role that pharmacists play in making this country's drug distribution system the envy of the world. APhA strongly believes that all patients receiving medication are entitled to comprehensive pharmaceutical services, including maintaining patients' medication profiles and counseling patients. These essential services are even more critical when providing care to the nation's elderly. Studies at the University of Michigan have shown that 15% of the elderly population takes four or more medications concurrently. The pharmacist's review of all medications taken by a patient plays an important part in avoiding serious drug interactions that may result in costly hospitalization. Often, an additional benefit of this information and review process is the ready availability of documentation of drug expenditures for the patient over a given period of time. We believe contemporary pharmacy practice is consistent with the role envisioned for pharmacists with respect to Medicare reimbursement for prescription medications.

The second issue I want to address is the need for this proposed bill to work in concert with existing state laws. The issues of multiple source drugs and a potential national formulary are ones where we particularly see this need. Let me preface my comments here by saying that APhA recognizes and endorses the desire of Congress to contain costs in the Medicare program by encouraging pharmacists to select and dispense less expensive multiple source drugs when appropriate. We believe, however, that because there are different drug product selection laws in all fifty states, inconsistencies may arise concerning what constitutes a multiple source drug for purposes of reimbursement under this bill. For example, certain drugs identified by FDA as therapeutic equivalents are not so recognized in certain states for purposes of their drug product selection law. If the state law does not permit a pharmacist to select from among those therapeutic equivalents recognized by FDA, the pharmacist is forced to dispense the drug specifically named in the physician's prescription order. In this situation APhA believes that state drug product selection laws should prevail for such determinations.

APhA opposes the feature of the proposed bill authorizing the Secretary to develop a national formulary. APhA believes that the current efficiency of state drug product selection laws promotes the outcome desired by the use of a formulary. Further, a national formulary would be cumbersome to develop, continually revise and disseminate to participating pharmacies. It would likely come into occasional conflict with various other formularies. And, it might create possible delays in availability of new therapeutic entities.

APhA supports the inclusion of a limit on the supply of medication dispensed at any one time, as has been proposed in this bill. However, APhA believes that the limit should be set at a thirty day supply of medications. A thirty day limit would be consistent with many programs that have regulations restricting the amount of medication that can be dispensed at a given time. Such a limit reduces waste, stockpiling, overutilization and abuse of medication while allowing an opportunity for timely physician and/or pharmacist re-evaluation, dosage adjustment and additional medication counseling when necessary. We respectfully urge the Committee to consider including a provision in the proposed bill explicitly recognizing the application of state laws where appropriate. In those states where no such laws exist, a thirty day limit should apply.

The third issue concerns certain aspects of the proposed reimbursement mechanism. Let me begin by saying that APhA supports a reimbursement mechanism that establishes adequate reimbursement for pharmacists so that they will be financially able to participate in the proposed program. Since the market for prescription medications and pharmaceutical services is a highly competitive one, our position is that market place pricing, with percentile screens to prohibit unusually high pricing, should be used in reimbursement systems whenever possible. We would be pleased to work with the Committee staff to show how such a system can be implemented. At this time we are prepared to support the use of actual charges or national average wholesale prices plus a regularly updated fee for computation of reimbursement rates for drug products under the proposed bill as fair reimbursement. We do, however, have serious concern about its actual implementation given our experience under the Medicaid program. Medicaid reimbursement which uses a cost plus fee approach has over time produced reimbursement levels that are totally inadequate for the services performed by pharmacists. Thus, we believe that if the suggested mechanism is used, the fee must be updated annually to ensure adequate compensation.

We also urge that monthly wholesale price updates be recognized as necessary to give pharmacists fair and adequate reimbursement for drug products they dispense. When product price increases by manufacturers occur, the impact upon the pharmacist is immediate. Pharmacists should not be asked to absorb these increases. Information is readily available to update drug price data bases easily. We believe it is reasonable to reimburse pharmacists based on a current and realistic national average wholesale price. Moreover, base drug prices should only be derived from the prices of prescription drugs that are generally available to pharmacists nationwide.

With regard to the issue of the proposed coinsurance, APhA believes that the proposed bill should be consistent with the catastrophic insurance bill's philosophy applicable to catastrophic medical expenses, which places a cap on potential monetary losses. If the philosophy underlying the bill is to ensure that no Medicare beneficiary has to pay out-of-pocket more than a predetermined amount of money, then a coinsurance provision applicable only to prescription medication expenses is inappropriate. We therefore urge the committee to eliminate the coinsurance provision from the proposed bill.

Finally, I want to mention a significant procedural aspect of the reimbursement mechanism. APhA is pleased to see reference to electronic claims processing and supports such development. The timetable established in the proposed bill is reasonable. In the interim, APhA urges the use of the universal third party claim form, which is in use today in virtually every pharmacy in the country and can be processed by most available pharmacy computer software systems. Use of this form would substantially enhance acceptability and efficiency. Thus, we respectfully urge that the proposed bill include a requirement that the currently available universal claim form be used for pharmacist reimbursement.

In conclusion, on behalf of APhA, I want to commend the sponsors of this bill for their foresight in drafting legislation to provide for this much needed coverage of prescription medications and pharmaceutical services. APhA is eager to continue to work with the Committee and its staff on this important health care issue.

Chairman STARK. Thank you very much.

Mr. Rector?

## STATEMENT OF JOHN M. RECTOR, GENERAL COUNSEL AND VICE PRESIDENT FOR GOVERNMENT AFFAIRS, NATIONAL ASSOCIATION OF RETAIL DRUGGISTS

Mr. RECTOR. I am John Rector with the National Association of Retail Druggists. We are pleased to be here again. We will not reiterate and go through all the details of the statement we presented to the Committee on April 23.

I would like to speak specifically to several of the points in the draft proposal. Starting with the coinsurance, with the exception of some circumstances raised when a sole source drug is involved, we certainly endorse the concept of the 20-percent coinsurance.

Regarding the administrative fee——

Chairman STARK. Excuse me. Is that as opposed to a flat dollar fee?

Mr. RECTOR. As opposed to a flat dollar fee. There is some thought—I do not have to tell you that this has been moving right along—so we are giving additional thought to the sole source circumstance. But we do not want to penalize a person who is exposed to a sole source drug.

On the other hand, where there are multiple choices available, a 20-percent coinsurance seems to make more sense to us.

On the administrative allowance, we recommend that it be annually linked to the CPI. Regarding the formulary, it could, as some have mentioned today, prove to be complex and perhaps costly to operate. We certainly suggest a very careful review of that matter.

As the chairman intimated just moments ago, it would be possible to stage the program in a way that you could take a wait and see in the formulary, after a period of time subject to specific criteria and determine whether or not a formulary would make as much sense as the proponents of formularies are indicating.

I should mention on the note of formulary, a lot will be said by some in the pharmaceutical industry regarding studies of formularies to date. Our knowledge is that most of the studies, if not all of those studies of formularies have been in the Medicaid context, in the impoverished, poverty level context, and have, in fact, on occasion led to unnecessary hospitalization and so forth.

It would be our initial guess that that would not be the circumstance in the Medicare population and the recipient population addressed by the bill that you are presenting.

Regarding the electronic billing, we certainly support that. We would like to work with you a little more on the definition of "rural." We support a 34-day or 100 dosage units limitation like the State of Wisconsin has employed, like the State of Ohio and some others have employed, to avoid the common problem of wastage that has been experienced by so many programs. We mention in our statement the Lady Garment Workers Union program where they do not permit anymore than a 30-day supply.

I would like to comment on two items, in addition. One, just reading the newspaper, frankly, HHS was talking about a $500 million cost of administering this particular program. That certainly got our attention. Just to review a few facts—at least those that are available to us—the administrative cost of all Medicare and Medicaid in the last fiscal year, at least according to Mr. Natcher, was $215 million.

[The following was subsequently received:]

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ociation of RETAIL DRUGGISTS

NATIONAL HEADQUARTERS

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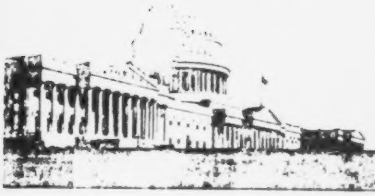

# WASHINGTON BULLETIN

July 31, 1986

## HOUSE VOTES TO SUPPORT ITS APPROPRIATIONS COMMITTEE'S REQUEST FOR MEDICAID DRUG VOUCHER

"*Federal administration.*—The bill includes $215,177,000 to support Federal administrative activities related to the Medicare and Medicaid programs. This is the same amount as the President's budget request and an increase of $9,357,000 over the amount available for FY 1986. The funds recommended by the Committee will support a staffing level of 3,757 full-time-equivalents for fiscal year 1987, a reduction of 124 FTE's from the number funded in FY 1986. The Committee has accepted this proposal based on the convincing testimony of the Acting Administrator that this would allow sufficient staff for program operations. This reduction will be accomplished through attrition.

During hearings on the FY 1987 budget request several witnesses testified regarding the complexity and cost of administering the prescription drug program under Medicaid. According to this testimony, drug claims, which account for only 8 percent of program dollars, account for more than 50 percent of all Medicaid paperwork. Given the need to reduce the portion of Medicaid's budget which is expended for administrative costs, the Committee believes that HCFA should aggressively address this problem. Prior to its hearing on the FY 1988 budget request, the Committee will expect to receive a report on the extent of the problem and on alternatives which might be tried in this area. These alternatives should include further expansion of electronic claims handling as well as drug vouchers if cost effective."

House Rept. 99-711, p. 106; H.R. 5233, making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies, for the fiscal year ending September 30, 1987. July 24, 1986

Mr. RECTOR. We were shocked to see this Bowen $500 million figure. We have made many recommendations in the Medicaid context— and of course, that is the only context that we have had the opportunity to address to date—for vouchers, for electronic billing, for the debit and so forth, as have the chain drug organizations, and they have fallen on deaf ears.

Now, it appears that when it comes to the Medicare outpatient, HHS is taking this same costly overhead program to make a current estimate, and an excessive estimate at that, as to the administrative costs associated with your proposal, and that made by Mr. Waxman.

On that point, we reiterate the efficacy, in our view, of the utilization of vouchers and the electronic transfer. In the States where programs have been employed, such as Blue Cross/Blue Shield in Delaware, the perclaimed cost have been reduced by two-thirds in their drug program, to 20 percent.

Several of your witnesses today have raised an issue of confiscating the discounts that pharmacies earn and the relationships that they have with their wholesalers. We will supply for the record of the committee and its Members further discussion on that point.

[The following was subsequently received:]

**Attached are the materials in response to questions raised about the confiscation of earned discounts and documentation on the cost of the Medicare/Medicaid administration.**

## STATEMENT OF JOHN M. RECTOR, ESQUIRE
## BEFORE THE HOUSE LABOR HEALTH AND HUMAN SERVICES EDUCATION AND RELATED AGENCIES APPROPRIATIONS SUBCOMMITTEE

May 22, 1985

## HCFA - FISCAL YEAR 1986 APPROPRIATIONS

Mr. Chairman, Members of the Subcommittee:

I am John M. Rector, Director of Government Affairs for the National Association of Retail Druggists ("NARD"). With me today is Richard M. Rindler, a partner in the firm of Pepper, Hamilton & Scheetz, and antitrust counsel to NARD.

The National Association of Retail Druggists represents owners of more than 30,000 independent pharmacies where over 75,000 pharmacists dispense more than 70 percent of the nation's prescription drugs. Together, they serve 18 million persons daily and provide nearly 85 percent of the Medicaid pharmaceutical services. More than 60 percent of our members are currently involved in providing home health care. NARD has long been acknowledged as the sole advocate for this vital component of the free enterprise system.

We appreciate the opportunity to address the Subcommittee on such short notice. The matter with which we are concerned is a matter of extreme urgency to the members of NARD. HCFA has threatened to cut-off the federal contribution for drug reimbursement under Medicaid in Arkansas, Louisiana, Texas, Oklahoma and New Mexico by July 1, 1985. HCFA has threatened to cut-off the federal contribution for drug reimbursement under Medicaid in Montana, Wyoming, Utah, Colorado, South Dakota and North Dakota by August 1, 1985. In fact, in a recent letter from the regional HCFA administrator in Region VIII it appears that HCFA intends to cut-off all federal funding for drug reimbursement under Medicaid in all states that fail to adopt a HCFA mandated method of drug product reimbursement. A copy of that letter is attached.

HCFA's decision to impose a mandated method of product reimbursement is an admitted policy change.* This change in

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* The genesis of this policy change was an Inspector General's Report. The Report 06-40216, which is attached for the record, stated that its findings "demonstrate the need for revision of the Medicaid policies and regulations." The Inspector General recommended that "the revised regulations should eliminate the use of AWP [average wholesale price] and require State Medicaid agencies to aggresively pursue alternative methods for establishing upper reimbursement limits." (Emphasis added.)

Carolyne Davis, HCFA Administrator, in her response to the Inspector General, which is attached, acknowledged that the Inspector General's recommendations would involve a change in policy and regulations. In that response she indicated that any changes would be tabled until the Task Force on Reimbursement appointed by Secretary Heckler made its findings. Administrator Davis stated: "we are not prepared to recommend any change in Federal regulations at this time." (Emphasis added.)

Further confirmation of the fact that the mandated reimbursement method involved a policy change is provided by the fact that the state of Arkansas received a letter from HCFA stating that

(CONTINUED)

policy and regulation and HCFA's announced intent to cut-off funding has been undertaken without due process of law. There has been no Federal Register notice of the change. No opportunity for comment has been provided. None of the many procedural safeguards which Congress has enacted to protect small business and the American public have been utilized by HCFA. On May 8, 1985 Charles West, Executive Vice President of NARD, testified before this Subcommittee on the question of fiscal 1986 appropriations for HCFA. A copy of that statement is attached. In his statement Mr. West details more of the history of HCFA's total disregard for procedural due process as well as the severe impact of the proposed change which seeks to take away a pharmacists earned discounts. Since Mr. West's last appearance before this Subcommittee, HCFA has proceeded to threaten to cut-off funding to additional states.

The threatened action by HCFA, if allowed to proceed, could cause substantial harm to citizens in all impacted states, severe damage to the Medicaid system and the elimination of a number of retail pharmacies. Since the inception of Medicaid, the number of retail pharmacies have been reduced from 50,000 to 30,000. To suggest, as HCFA's Administrator Carolyne Davis has,

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Arkansas was in full compliance with existing HCFA regulations after the Inspector General's audit.

that pharmacists must be happy with the program since so many participate in the program, is to ignore two fundamental points. First, pharmacy believes it has a public service obligation and has rightly, or from a self-interest point of view, wrongly, continued to participate in the Medicaid program even though reimbursement under the program has been inequitable. To some extent pharmacy has shifted the burden of inequitable Medicaid reimbursement to the non-Medicaid patient. This form of coerced cost shifting and indirect tax subsidy is totally inappropriate as a matter of public policy. Secondly, Administrator Davis' statement ignores the fact that there are 20,000 fewer retail pharmacists today than when Medicaid began. Those pharmacists no longer participate in the Medicaid program. Many of those pharmacies, which are no longer in business, were in urban areas or remote rural areas where there are heavy Medicaid populations. In those areas the independent retail pharmacist is frequently the sole ready source of health care information. In part, as a result of the Medicaid reimbursement system, those pharmacies are no longer available to provide such assistance.

If HCFA is allowed to implement its illegal policy, I predict that there will be many thousands more retail pharmacists who will not participate in the program because they will not be in business. I also suspect that the gross inequity of the procedure used to change the HCFA policy, as well as the substance of the policy itself, will mean that many thousands of other retail pharmacists will determine, on an individual basis, that they can ~~no~~ longer economically participate in the program.

HCFA's ill-thought out and unlawful attempt to impose upon the states a specific reimbursement system violates HCFA's own regulations and numerous statutes passed by Congress in connection with what is supposed to be a federal funded, state run Medicare/Medicaid program. HCFA's actions also violate the general administrative procedures which appropriately limit the conduct of administrative and executive agencies. This Committee should stop HCFA's action by forbidding HCFA to expend any funds appropriated in either supplemental appropriations for fiscal year 1985 or any funds appropriated for fiscal year 1986.

The severity of the problem is well illustrated by the fact that the Louisiana State Committee, which oversees that states participation in Medicaid, has recommended on the basis of HCFA's attempt to recapture pharmacies earned discounts to withdraw totally from the Medicaid program. This serves neither Congress's interest or the public welfare. This committee should direct HCFA to stop all steps involved in the implementation of this illegal program.

## VI. Medicaid Prescription Drug Draft (Voucher) Program *

In an era of staggering deficits and tightening budget constraints, the need for containing government program costs is essential. Many initiatives are being undertaken to reduce health care expenditures. These initiatives include proposals to set further limits on the reimbursement paid to pharmacists for providing their services to Medicaid recipients. Other mechanisms for containing costs should be explored in order to reduce other program costs related to maintaining the Medicaid program. The use of a Medicaid prescription drug draft (voucher) system is one proposal which, based on a conservative estimate related to claims processing, can save taxpayers greater than $420 million in administrative expenses over a five year period. In addition, this system also achieves prompt payment, which meets current government initiatives.

Administrative costs include the amount of money paid to a vendor to process claims, printing of the claim forms, and the salaries of the program's staff pharmacists, investigators, clerical personnel and program administrator. Cost reductions in this area are possible through the use of claims processing systems which are much more efficient and substantially less expensive than the current systems. A drug draft or voucher system can provide greater efficiencies and lower costs by utilizing the existing structure and proven expertise of the national banking system. A program which results in a 66 percent reduction in administrative expenses, and is much more acceptable to the pharmacist in terms of reimbursement, is one which deserves serious consideration.

A prescription drug draft program to reimburse pharmacy services was first used in the Alabama Medicaid program and is currently being used by Blue Cross/Blue Shield in the state of Delaware. It is proposed that a Medicaid Prescription Drug Draft (Voucher)

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* Part of PraCon study presented to NARD entitled "Marketplace Economics: Alternatives in Medicaid Prescription Reimbursement"

Program should be initiated which benefits taxpayers by preventing their tax dollars from being needlessly wasted; benefits the government by meeting cost reduction initiatives and operational efficiencies; and benefits pharmacists by providing them with fair and timely reimbursement for their services. The analysis of these programs which follows provides greater insight into this proposed system.

## Alabama Pharmacy Bank Draft Program

The Alabama bank draft program which was introduced in 1970, received a citation in 1976 from the Department of Health, Education and Welfare, which was presented, "...in recognition of demonstrating extraordinary awareness and front-end management of an innovative bank draft system of drug payments that has significantly reduced many problems experienced by other states."

This system used a two-part draft which was provided by the state to the pharmacy participants. Unlike food stamps, potential fraud was limited since it was only the pharmacist who had access to the draft. When a patient, enrolled in the Medicaid program, brought a prescription to the pharmacy, a plastic ID card was presented to validate eligibility. This card was then used like a credit card to imprint patient and program information directly on the draft. The remaining information was then completed by the pharmacist. Information on the draft included the National Drug Code (NDC) number, prescription number, refill status, physician ID number, and pricing information. The form was signed by both the pharmacist and the patient. Pricing information included the cost of ingredients, including earned discounts, the fee, and the deducted copay, if any.

Once the information was completed, the draft was deposited in the pharmacy's bank and credited immediately. The draft could only be deposited to the pharmacy's bank account and could not be cashed as a check. The bank then sent the draft with other checks, drafts, and negotiable instruments to a central clearing bank which separated them and encoded them with machine-readable data.

Once processed, the drafts were sent to the state Medicaid office to be audited. Initially, if a form was in error or if too large a claim had been made, a bill or corrective notice would be sent to the pharmacy on a monthly basis. Due to concerns that Medicaid would not be reimbursed promptly by the pharmacists, it was decided to treat the drafts in error as checks with insufficient funds. In this case, the pharmacy's bank account would be debited the sum of the draft, immediately transferring the funds back to Medicaid. If an error was present on the draft, it could be resubmitted. Any overpayment would have to be returned to the state by the pharmacy after receiving the bill. Other information was also readily retrievable from the draft. Drug utilization review was easily done by using the NDC number. Statistical reports were generated which were used for the Medicaid Management Information System (MMIS) and provided marketing data to the Medicaid program director indicating drug usage and dispensing patterns by provider and recipient. Problems could be identified quickly, allowing pharmacists to be informed immediately of claims to be returned. If a Medicaid recipient was violating the law by using multiple pharmacies for the same prescription, this abuse of the system could be identified within 24 hours. In this way, fraud and abuse were readily identified and halted. Inspector General Kusserow pointed out that traditional audits may be reviewed "...for months, before being passed on to interested parties..." The point of this comment is the long lag time to identify potential system abusers, thereby delaying a process which could halt fraud and prevent Medicaid dollars from erroneously being paid. The reports generated as a result of the draft system may help expedite this auditing process assuring that corrections which save expenses can readily be made.

Administrative program expenses were kept to a minimum. The state's cost for processing claims was 15 cents per draft. When other administrative expenses were added to the figure, the total administrative cost was 20 cents per draft. These administrative expenses included five clerical people, one administrative accountant, two pharmacists, the program administrators (5 percent of the time) and three investigators (70 percent of the time). Prior to this, Alabama was paying 45 cents to process each claim. Currently, state Medicaid programs pay approximately 60 cents to more than $1.00 per claim.

Problems which lead to the eventual demise of Alabama's program included a dislike of the "pay first" system by auditors. The "pay first" system meant that pharmacists would receive payment for their services first, followed by a review and audit of the claims being submitted through the pharmacy's bank. Other problems which troubled the draft system included complaints by other health care providers, including physicians and hospitals, who had to wait for their payment. Perhaps the major contributing problem was cash flow which resulted from insufficient funds available to pay for prescription services in such an immediate fashion. The end result of dismantling the drug draft system was to place the problem of cash flow back on the provider by delaying payments several weeks after the service and product had been delivered.

## Delaware Prescription Drug Draft Program

The Delaware Prescription Drug Draft Program was started by Blue Cross/Blue Shield in 1973 and is currently in operation. The program mechanics are similar to those described in the former Alabama program. Once again, a two-part form is used which gathers all pertinent information. One major difference is that the Delaware system provides an option for computer, pin-fed copies of the draft which can be run at the end of a business day on the pharmacy computer. Once completed, the pharmacist signs the drafts and deposits them in the bank. For those who do not have the available computer software or hardware, the manual system of filing the forms may be done as usual.

If the draft is properly filled out and patient eligibility is properly determined, the draft is deposited directly into the pharmacy's bank. Any drafts which are not complete will be returned as a check with insufficient information.

After payment, Blue Cross and Blue Shield of Delaware audits the drafts to verify eligibility, correct pricing and other submitted information. In the event of a discrepancy, the pharmacy is mailed a monthly notice. If the data is incorrect, the pharmacy can return accurate information to clarify the problem. If the pricing is in error or the patient is deemed ineligible, the pharmacy is billed for the difference and must make payment within 30 days.

Professional Relations Representative Juana Negri has stated that since she has been working with the pharmacy program she has "never had a problem receiving funds from the pharmacists. This is because they want to make sure the system works so they don't lose the program."

Shortly after the program was implemented, significant dollar savings comparable to those seen with the Alabama program were realized related to the cost of claims processing and paperwork was reduced by at least 50 percent. Ms. Negri estimates that the current cost of running their prescription draft program runs about 20 cents per claim.

Concerns with the Delaware program are similar to those experienced by Alabama. Frequently people in the accounting department complain about paying first and auditing later. She argues that, "with pharmacy, a product is involved that the pharmacy must pay for. A surgeon can take out an appendix and it won't cost him anything other than his professional time. A pharmacist not only has the cost of his professional time, but the cost of the drug as well." She believes that it would not be equitable for a pharmacist to cover the cost of a product when payment may not be received for six to eight weeks.

Ms. Negri also predicts that as the technology becomes available, the Delaware system will be able to be operated entirely by electronic transfer of information without having to generate the actual hard copy. When this system is implemented, those pharmacies unable to afford the necessary computer equipment will still be able to utilize the program in its original format and maintain the integrity of the information in the system.

## Benefit to Pharmacists

The current reimbursement mechanisms cause significant hardships on pharmacies providing services to Medicaid recipients. Based on information reported by the National Pharmaceutical Council, in 1984 Medicaid paid a mean average of $164,485,166 per month for prescribed drugs. While considering the number of pharmacies participating in Medicaid and an average 6 to 8 week turnaround time for claims processing, pharmacists were forced to carry an average of $3,712 to $4,950 in unpaid Medicaid claims at any given time during 1984.

Independent retail pharmacies process 80 percent of the prescriptions received by Medicaid recipients. It is particularly this group of independent businessmen who are forced to bare the brunt of expenses related to filling Medicaid prescriptions. By adopting a Medicaid Prescription Drug Draft (Voucher) Program, this money could be allocated to other business expenses and cost-effective pharmacy services and other business expenses.

Freeing this money, in some cases, may allow pharmacists to remain in the Medicaid program. It has been documented, that, in many instances, pharmacies have had to halt their participation in the program due to excessive late payments by Medicaid. This may be necessary even in the face of losing the business of other members of the recipient's family who are not receiving Medicaid benefits. Pharmacists may also be forced to make business decisions that will require dropping professional services in an effort to continue providing their Medicaid patients. The resulting loss will not only be felt by the Medicaid patients, but those non-Medicaid patients who previously benefitted from the lost service. The draft (voucher) system may prove to be a major factor in preserving the ability of the independent retail pharmacist to continue to serve the Medicaid population.

### Benefit to the Taxpayers and the Government

One of the major benefits of a Medicaid Prescription Drug Draft (Voucher) Program would be the substantial monetary savings in claims processing costs (see Table F). Had this program been in use during 1985, the estimated potential savings would have surpassed $73 million for the entire Medicaid program. A straight line trend analysis for the number of prescription claims was performed to determine the number of claims over the next five years, considering trends in the number of Medicaid recipients receiving prescription drug benefits. Assuming no changes in eligibility and a zero percent inflation rate, the estimated five year savings could be as much as $420 million (see Table G and Exhibit IX). This calculation was done based on a $0.60 per claim fee for the current system compared with a charge of $0.20 per claim under the drug draft (voucher) system. It

## TABLE F

## Potential Savings in Administrative Costs

## 1985

| | |
|---|---|
| Total Number of Medicaid Prescription Claims Processed for 1985 | 184,583,099 |
| Current Service Charge ($0.60 per claim) | $110,749,859 |
| Projected Drug Draft Service Charge ($0.20 per claim) | $36,916,620 |
| Potential Savings | $73,833,240 |

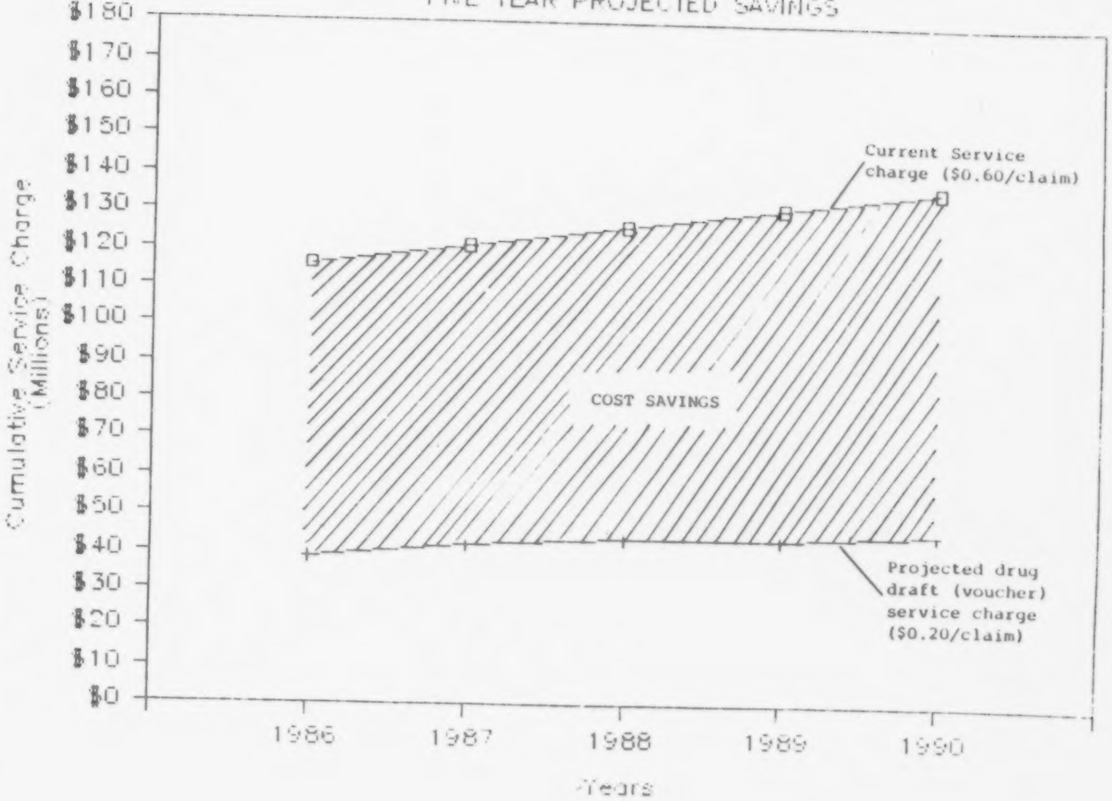
TABLE G

Five Year Projected Savings

| | 1986 | 1987 | 1988 | 1989 | 1990 | Total |
|---|---|---|---|---|---|---|
| Projected Number of Prescription Claims | 193,062,895 | 201,642,194 | 210,221,494 | 218,800,793 | 227,380,092 | 1,051,107,468 |
| Current Service Charge ($.060 per claim) | $115,837,737 | $120,985,316 | $126,132,896 | $131,280,476 | $136,428,055 | $630,664,480 |
| Projected Drug Draft Service Charge ($0.20 per claim) | $ 38,612,579 | $ 40,328,439 | $ 42,044,299 | $ 43,760,159 | $ 45,476,018 | $210,221,494 |
| Projected Savings | $ 77,225,158 | $ 80,656,878 | $ 84,088,598 | $ 87,520,317 | $ 90,952,037 | $420,442,987 |

## EXHIBIT IX

### FIVE YEAR PROJECTED SAVINGS



should be noted that in all cases, these are in fact conservative estimates; actual savings could be much higher based on the range of administrative costs from $0.60 to greater than $1.00 per claim. To complement these savings, based on the Delaware Blues' success, the program would have the potential of decreasing the paperwork related to Medicaid prescription drug reimbursement by 50 percent, decreasing the total Medicaid paper volume by 25 percent. This paperwork reduction results from taking advantage of the national banking system with its built-in efficiencies for handling financial procedures of this magnitude.

The amount of tax dollars spent on claims processing is clearly illustrated in information obtained from one state Medicaid program. The claims processing vendor will receive approximately $1.5 million in profits over a three year period beginning in 1987 which amounts to a 12 percent profit margin. Generally, most vendors realize a profit ranging between 12 and 15 percent. Reducing this profit margin would result in saving the Medicaid program added money. It is interesting to note that according to the 1985 Lilly Digest, pharmacies on the whole made a net profit of 3.1 percent. This same source indicates that only 11 percent of the pharmacies reporting had a profit margin of 10 percent or over, while 36 percent of the pharmacies either operated at less than a 2 percent profit margin or operated at a loss. These data suggest that there are other areas of expense to be reduced which have not been addressed before attacking the limited profit margin of pharmacies. Operating with such small margins makes it necessary to have as much available money freed for other purposes as possible. Instead of making it more difficult for pharmacies to operate, there should be more parity in profit allowances for all participants in the Medicaid program including vendors and pharmacists alike.

The Medicaid Drug Draft (Voucher) Program can be implemented in conjunction with any reimbursement mechanism set by HCFA and still meet the drug draft programs's objectives to reduce administrative costs. The mechanism for determining the reimbursement rate is independent of the claims processing function. As technologies change, the drug draft (voucher) system would also be easily transferrable to a computer program which will still be compatible with the paper draft system.

It should also be considered that filling Medicaid prescriptions for less than the pharmacy's cost often results in shifting of those costs to the private sector. Many of those people in the private sector include older people on a fixed income. Although their financial situations do not allow them to be eligible for Medicaid benefits, they are in effect helping to subsidize the Medicaid patient. This is particularly significant because this segment of the population uses a higher number of prescription drugs. This essentially results in an added taxation on a non-Medicaid patient population which can ill afford added expenses.

Finally, the system provides for drug utilization reviews (DURs) to be easily done by all state Medicaid programs. This is an important aspect of cost containment, as seen with the DUR program reported by the Virginia Medicaid program which estimated an annual savings of $409,000 per year from the prevention of 452 patients hospitalization. Currently, DUR is not performed in all state Medicaid programs since the necessary information is unavailable from MMIS. It is this type of quality information that would allow states, at a local level, to determine prescribing trends and identify other areas for potential cost savings.

## Recommendation and Conclusion

It is recommended that a Medicaid Prescription Drug Draft (Voucher) Program be adopted by the state Medicaid programs on a national basis. The federal government should set a mandate that state governments implement this program as soon as possible to assure that pharmacists receive prompt payment for their services as directed by current initiatives. Ideally the system should provide a standard form or Universal Draft which collects the same basic information for each program. Use of a Universal Draft would allow all data to be easily compiled on a national basis for evaluation and review. This information could allow for a national DUR to allow states to compare their progress in areas of cost control with other states. Information could also provide valuable post-marketing surveillance data. This can be used to identify trends signalling potentially new adverse drug reactions or interactions which could be readily communicated to both pharmacists and physicians to provide them with information to prevent further adverse reaction. To allow for these benefits, information on a two-part form should minimally include the National Drug Code, drug quantity and prescription number, pricing information, a pharmacy code, a physician code, the date dispensed and other patient and program specific information.

Start-up costs will be a one time investment in a program that has the potential to save a significant amount of money for many years. Initial costs should be minimal since the system takes advantage of a claims processing technology already existing in the banking industry. Production of the new draft forms and plastic recipient ID cards would comprise most of the initial costs.

Other variations of the system and their related costs may best be addressed during a pilot program. Options may include the use of direct electronic transfer and payment of drafts or immediate verification of a recipient's eligibility for service just as a person's credit card is checked for payment authorizations.

The Medicaid Prescription Drug Draft (Voucher) Program can be equitable to pharmacists, cost effective to taxpayers and allow streamlined operations for both the federal and state governments. This program takes advantage of the sophisticated claims processing system already in use by the banking industry, a system which has excellent proven capability. Prompt payment for services is an additional benefit of this system. By using the business expertise of private enterprise, the government's Medicaid program can dramatically improve its efficiency as the data presented here has shown. It is strongly encouraged that action be taken in this direction to effectively deal with the Medicaid program which grows more difficult to administer as time passes.

Congreſs of the United States
House of Representatives
Washington, D.C. 20515

February 28, 1985

Carolyne K. Davis, Ph.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
200 Independence Avenue, S.W.
Room 314G Humphrey Building
Washington, D.C. 20201

Dear Dr. Davis:

We would like to take this opportunity to commend your efforts and those of Secretary Margaret Heckler in embarking on a comprehensive review of the Medicaid prescription drug program through the commission of the Task Force on Reimbursement for Prescription Drugs. This area is one in which there is significant opportunity for reform, and we support any efforts to ensure that the most appropriate reimbursement mechanisms possible are used in federal health care programs. We look forward to working with the Administration in this area when the task force has completed its work.

However, it has recently come to out attention that, as a result of a September 1984 report from the Office of the Health and Human Services Inspector General, Health Care Financing Administration (HCFA) Region VI officials have directed the state Medicaid bureaus in that region to make adjustments in the estimated acquisition cost (EAC) currently used to determine reimbursement levels for drugs under the Medicaid program. These efforts have raised a number of very legitimate concerns among the pharmaceutical providers in Arkansas and other states in the region.

First, we are concerned that an across-the-board reduction in state pricing levels may overestimate certain pharmaceutical providers' earned discounts, particularly smaller independent pharmacies, and implementation of the reduction may act as a strong disincentive most particularly for some of Arkansas' smaller and more rural pharmacies to continue their dealings with Medicaid beneficiaries. This could severely limit these beneficiaries' access to much needed pharmaceutical services.

In addition, the HCFA Region VI initiative is very limited in scope. Any recomputation of the EAC may precipitate a movement for changes in other components of the program (such as an increase in the dispensing fee), which may significantly reduce any savings resulting from the EAC changes.

Finally, we would like to point out that, while HCFA is urging the EAC recomputation for states in Region VI on the grounds that many pharmacies are receiving significant discounts on their products which are not passed along to the Medicaid program, these discounts are based on pharmacies' private patient business as well as Medicaid business, and are frequently achieved only as the result of prudent business practices on the part of the participating pharmacy.

Because of the importance of the work that the task force is doing, we agree with your assessment that any major changes in the prescription drug pricing mechanism would be premature at this time. For this reason, we respectfully urge you and HCFA Region VI officials to delay any efforts in this area until such time as the Department has completed its review of the national Medicaid prescription drug program.

We thank you for your consideration of this request.

Sincerely,

John Paul Hammerschmidt
John Paul Hammerschmidt
Member of Congress

David Pryor
David Pryor
United States Senator

Bill Alexander
Bill Alexander
Member of Congress

Beryl Anthony Jr.
Beryl Anthony, Jr.
Member of Congress

Tommy F. Robinson
Member of Congress

Urging the House Subcommittee [illegible] appropriations to [illegible] with major Medicaid drug reimbursement policy changes [illegible] volved in the policy are NARD representatives and three influential members of [illegible] govt affairs. Rep. Bob Livingston (R.-La.), Rep. Lindy Briggs (D.-La.), Rep. Bill Alexander [illegible] Their appearance took place concurrently with the NARD legislative conference.

## Washington Legislative Conference:

# NARD Zeroes In On Discriminatory Pricing And The Earned Discount

### Independent RPhs exchange views with political leaders on matters vital to economic survival

NARD executive vice president Charles M. West set the tone for the association's 17th annual conference on national legislation and public affairs when he outlined the two critical issues facing independent pharmacists: discriminatory pricing by manufacturers and wholesalers to nonprofit entities, and the campaign to eliminate the earned discount in the Medicaid pharmacy program.

Mr. West told independent pharmacists and state association executives at the Washington meeting that they should meet with their Congressional representatives during the week in order to publicize retail pharmacy's concerns on these issues.

**Wants fair competition:** The NARD executive called for the repeal or modification of the 1938 Nonprofit Institutions Act because of its current abuses. He said that HMOs claim exemption from the antitrust laws but operate in competition with retail pharmacies. "No one receives free care from HMOs; in order to obtain care you have to be a paying member. To call Kaiser a charity is an abuse of the term."

Mr. West said that consumers pay twice; first, in taxes to subsidize commercial nonprofits, and then again in increased drug prices due to cost shifting by manufacturers. He also noted that retail pharmacists, who are pharmaceutical manufacturers' best customers, "take it on the chin" from the paying public for drug price increases.

**Earned discount:** Mr. West berated the Health Care Financing Administration's shift in policy which would eliminate earned discounts for pharmaicsts participating in the Medicaid program. He said that this "anti-small business" policy ignores the

*(Continued)*

**NARD ZEROES IN**

*(Continued)*

Congressman Henry A. Waxman (D.-Calif.) is presented the NARD Congressional Ask Your Family Pharmacist Leadership award for the 98th Congress by Lonnie F. Hollingsworth, P.D., chairman of the NARD executive committee. Rep. Waxman in his remarks to independent pharmacists predicted that, if they haven't already done so, health insurance plans will mandate the use of generic drugs. He also recommitted himself to passage of his Compassionate Pain Relief Act which would allow the use of heroin on a trial basis for terminally ill cancer patients. In addition, he expressed philosophical problems with the idea of a "legend" class of OTC drugs.

fact that discounts are based on the entire business relationship with a wholesaler and not solely on the Medicaid portion of the business. He noted that "by eliminating the incentive of discount, the new policy encourages less efficiency in the delivery of prescription drugs and jeopardizes the Medicaid drug program."

The HCFA policy change is based on an Office of Inspector General (OIG) recommendation that states relying on average wholesale prices (AWP) should develop a different formula for determining pharmacist acquisition costs because AWP is generally higher than acquisition costs.

**Breach of faith:** A background on the potentially devastating effect of the OIG recommendation was supplied to the conference by NARD's director of government affairs, John Rector. Mr. Rector noted that in the fall of 1983, HHS conducted what many thought were "good faith" hearings on pharmacy and Medicaid. Almost simultaneous with this overall review, chaired by HHS asst secty Robert Helms, the "fraud oriented" Office of Inspector General began to investigate the ingredients aspect of Medicaid reimbursement for pharmacy. Mr. Rector said that almost as if listening to a "different drummer," OIG ignored the comprehensive approach that had been set out by HHS, and began conducting Medicaid audits in Region VI and elsewhere.

Mr. Rector observed that over a period of six months a variety of Reagan appointees had the opportunity to comment on the activities of the Inspector General as to whether the audits were appropriate in view of the more comprehensive review underway by HHS of the entire pharmacy Medicaid program.

The NARD government affairs director characterized the actions of HHS as a "breach of faith." He added that pharmacy "has been had" with regard to an HHS comprehensive review. "They have lied about their intentions; they have misled."

As an example of Administration double dealing, the NARD executive reported that "as recently as seven weeks ago" a regional administrator in Region VI assured Rep. Boggs and other Louisiana leaders that there was no intention to demand changes in the discount side of the equation in the Medicaid drug program. Mr. Rector said that within hours of this assurance, a letter was in the mail putting Louisiana on notice that effective July 1 federal funds for Medicaid would be reduced by the percentage attributable to the elimination of the earned discount.

Mr. Rector said that the Health Care Financing Administration (HCFA) is persisting in its efforts to sabotage the earned discount. He assured the NARD members in the audience, though, that "fortunately, we have numerous allies in the House and Senate."

**Victories:** Gains for retail pharmacy in the short and long term did result from face-to-face meetings with legislative leaders. NARD members received a sympathetic hearing from legislators on a wide array of issues, particularly the two they were most concerned about: discriminatory pricing and the earned discount.

Significantly, a special emergency hearing of the House Appropriations Committee was called. At this meeting John Rector and NARD antitrust counsel Rich Rindler, along with three influential members of the committee—Reps. Lindy Boggs (D.-La.), Bill Alexander (D.-Ark.) and Bob

*(Continued)*

[illegible]

**Since a major thrust of NARD's legislative conference was to make sure that the earned discount in the Medicaid pharmacy program is retained, it was appropriate that the leadoff guest speaker was the person considered to be the villain in the scenario endangering equitable drug reimbursement policies—Richard P. Kusserow, Inspector General of the U.S. Dept. of Health & Human Services.**

**Mr. Kusserow, who was appointed to his position in 1981, started his prepared remarks by emphasizing the independence of his office which has statutory authority to seek out waste, fraud, abuse and inefficiency in HHS, the largest agency in the federal government. He also stressed that he cannot make policy, although he may be able to influence it. Until his appointment, HCFA programs were never looked at, and neither, for that matter was the vast social security program, said Mr. Kusserow. He stated that HCFA was not, to put it mildly, receptive to investigators nos-**

Inspector General Richard Kusserow sticks to his guns that AWP is not realistic and should not be used as a basis for establishing estimated acquisition cost. Looking on is NARD president John W. White, P.D.

*(Continued)*

## NARD ZEROES IN

*(Continued)*

Livingston (R.-La.)—spoke in favor of NARD-endorsed language that would prevent HHS and HCFA from eliminating discounts earned by pharmacists in the Medicaid drug program. Sitting in on the panel were chairman William H. Natcher (D.-Ky.); Silvio O. Conte (R.-Mass.), ranking minority member; John Edward Porter (R.-Ill.); and Steny H. Hoyer (D.-Md.). (Similar testimony by John Rector and Charles West was presented to the Senate Appropriations Committee on May 8.)

Also with regard to the earned discount, one of the NARD invited speakers, Sen. Thad Cochran (R.-Miss.), called HCFA and was assured that nothing would happen in Region IV before October 1.

Another speaker, Frank S. Swain, chief counsel for advocacy of the Small Business Administration, promised to investigate the circumstances whereby the Inspector General acted in disregard of the regulatory review process, particularly requirements of the Regulatory Flexibility Act.

## Drug Diversion To Be Investigated By House

Rep. Gerry Sikorski (D.-Minn.) tells independent pharmacists how he is helping lead the fight in Congress against drug diversion and drug counterfeiting.

The "gray market" in drugs was attacked by Rep. Gerry Sikorski (Dem.-Minn.). He told his audience of independent pharmacists in Washington that he was concerned about "bargain price" drugs getting to the public. He said: "When it comes to drugs, I want to be doubly sure that the quality of the product has been maintained from the moment it is made right up to the moment it is consumed. And I want to eliminate any risk of counterfeiting."

Rep. Sikorski said that the areas of drug diversion and drug counterfeiting will be examined by the House Energy & Commerce Committee's subcommittee on Oversight & Investigations, of which he is a member. He noted that there are several techniques being used to divert drugs, including foreign buyers getting English labels on drugs for "prestige" purposes, and the shipment never getting overseas.

The Minnesota congressman also cited bargain-priced large orders with "excess" purchases ending up in the marketplace.

He also mentioned loopholes for "nonprofit" institutions that do not deserve exemption from Robinson-Patman. Enterprises, he said, have been formed solely to take advantage of these loopholes in the antitrust law.

Pharmacists with evidence of diversion or counterfeiting were invited to present it to Rep. Sikorski or the subcommittee chairman, Rep. Ding

## INSPECTOR GEN'L

*(Continued)*

ing around for waste and inefficiency.

To indicate the efficiency of his office, Mr. Kusserow noted that in 1981 $165 million was collected in restitution and recoveries while last year $3.7 billion was returned to the government. In 1981 there were 166 felony convictions, and last year 900. He told the pharmacists present that since August 1983 "we picked out 125 people from your profession" for engaging in fraud.

**Not realistic:** Mr. Kusserow consistently stuck by his original recommendation that average wholesale prices (AWP) used as a basis for establishing estimated acquisition cost (EAC) should be abandoned. He said AWP is not realistic in that it does not accurately reflect the generally lower prices that pharmacies pay for drug products. He did concede, though, that a comprehensive review of pharmacy reimbursement under Medicaid should preclude "piecemeal" cost cutting.

**Helms report:** In Mr. Kusserow's prepared remarks and throughout the sometimes heated question and answer period there were repeated references to the HHS task force on prescription reimbursement headed by Robert Helms, Ph.D., acting asst secty for Planning & Evaluation. Since NARD and other pharmacy organizations had been assured that there would be no major policy changes with regard to pharmacy reimbursement under Medicaid until the task force made its report, several at the session berated Mr. Kusserow and HCFA for intitiating reimbursement changes prematurely.

California pharmacist Fred Mayer pleads with Inspector General Kusserow not to squeeze more pharmacies out of business with his policies.

Just what is the status of the Helms report? According to Mr. Kusserow the task force has not been able to gain a consensus at the staff level. He indicated that a "decision memorandum" is being prepared for HHS Secretary Heckler setting forth options and asking for her guidance as to "which direction we should go." When this happens, everything will

*(Continued on P. 46)*

### INSPECTOR GEN'L

*(Continued from P. 28)*

be out in the open, according to the Inspector General, and everyone should be forced to say what he or she favors and opposes.

Mr. Kusserow and the participants at the conference seemed to agree that HCFA should focus on a "comprehensive" prescription policy and not look at things "piecemeal." The Inspector General said that HCFA should be putting its energies in moving the task force recommendations to the Secretary.

**Squeeze play:** Fred Mayer, owner of Sausalito Pharmacy in California, said that inadequate reimbursement was driving pharmacies out of business. He asked Mr. Kusserow: "Why not eliminate the whole prescription drug program under Medicaid rather than put us out of business and squeeze and squeeze? Can you at least make a recommendation to HCFA to hold off until we can at least get this impact on small business and show what effect it's going to have on the pharmacies that are left?"

To a round of applause from grateful independent pharmacists, Mr. Kusserow answered that he'll be "more than happy" to talk to HCFA chief Carolyne Davis. He said it's within her province. "I can show her the facts and she can act on them as she deems them to be appropriate."

**Other points** made by Inspector General Kusserow in response to questions.

■ "I'm not going to balance the budget on your backs. At the same time, you are part of the health care industry. We have to get HHS to have sufficient will to focus in on a public debate; that's why I joined the task force."

■ "I couldn't agree with you more [about the government playing a shell game in taking from one and from the other]." What you have, he said, are competing federal and state interests with Medicaid and Medicare.

■ The auditee—the state—has to have the results of an audit. There is an unfortunate risk of the report getting xeroxed and being leaked.

■ "I'd like to see Medicaid and Medicare become as timely [with regard to payments] with you folks as you have to be with your suppliers."

■ "It would certainly make a good argument [that pharmacists can save money through their counseling activities]. That is a very good case. They may not know for a fact that you deliver a very important service in dispensing those drugs."

—K[illegible] M[illegible]

## Less Money, More Jobs?

Cong. Trent Lott (R.-Miss.), Minority Whip of the House, made a pitch for a bill which would lower the minimum wage for youths seeking part-time employment. The idea is that a lower payroll would encourage employers to hire additional youths for employment. During a question and answer period, the idea was endorsed by pharmacy owner Donald Arthur of Tonawanda, New York, a member of the NARD executive committee.

# Victory on earned discounts

## HCFA Surrenders to Intense Congressional Pressure

Pharmacy and NARD have realized a political victory of nearly unmatched proportions: The Department of Health and Human Services and its Health Care Financing Administration have unconditionally surrendered in the war over HCFA's attempts to alter Medicaid drug reimbursement policies.

However, even after HCFA and HHS had in fact rescinded the policy changes their regional employees had tried to force on the states, the agencies continued the pattern of obfuscation that has marked their behavior during NARD's yearlong struggle.

On September 4 of this year—the eve of the House Appropriations Subcommittee meeting scheduled to vote on NARD's proposed amendment to prevent HCFA's confiscation of pharmacists' earned discounts—high-level HCFA and HHS officials informed regional officials *in every state* that efforts to change Medicaid drug reimbursement policies would stop. But in subsequent meetings with pharmacy representatives, some regional officials made no mention of the reversal.

> **NARD pulled out every political stop imaginable in a yearlong campaign to derail HCFA's initiative**

Nevertheless, HCFA's decision is a bright victory for NARD and the independent retail pharmacists it represents—especially in light of the fact that pharmacists in Region VI states fully expected to see the policy change take effect as early as January of this year. As a result of concerted efforts by NARD, by several state and national pharmacy organizations, and by members of Congress working on NARD's behalf, HCFA repeatedly delayed implementation of the policy change. The result: Pharmacists across the country were saved millions of dollars that HCFA would have confiscated under the proposed policy change. One government estimate put the amount HCFA would have taken from pharmacists at $128 million in a single year.

### NARD action

Fully a year ago, in October, 1984, NARD's House of Delegates passed a resolution condemning the audit report by the HHS Office of the Inspector General that prompted regional HCFA officials to attempt the unauthorized policy change that would have drastically slashed pharmacists' Medicaid reimbursement. In December, 1984, NARD Executive Vice President Charles West and Government Affairs Director John Rector traveled to

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Dallas for a strategy session with pharmacy executives from the besieged states. The next month NARD brought pharmacists from the Region VI states to Washington to meet with their congressional delegations on the proposed policy change.

### HHS and HCFA have unconditionally surrendered in the war over pharmacists' earned discounts

Since that time, NARD has testified before both the House and Senate on HCFA's failure to follow provisions of the Administrative Procedures Act and the Regulatory Flexibility Act, brought the HHS inspector general himself to NARD's legislative conference, at which he condemned HCFA's action, assembled pharmacy leaders from across the country at the conference to take their opposition to the proposed policy change directly to Capitol Hill, worked closely with the Small Business Administration's Chief of Advocacy, who subsequently called for a halt to HCFA's illegal activities —indeed, pulled out every political stop imaginable in leading pharmacy's fight to stop HCFA dead in its tracks. (See the "Legislative Roundup" on page 81 for a chronology of NARD's yearlong campaign.)

Finally, seven national associations representing the pharmaceutical industry were compelled to jointly file suit against HCFA and HHS to prevent their unauthorized and illegal activities. That lawsuit was filed in the United States District Court in Washington on September 16. HCFA didn't bother to tell pharmacy lawyers that it had in fact reversed its decision to proceed with the reimbursement policy changes nearly two weeks before. Instead, agency officials attempted to mollify the pharmacy plaintiffs with a letter that only hinted at part of HCFA's complete policy reversal. But because attorneys for the pharmacy associations remained unsatisfied with HCFA's meager response, the agency ultimately had to admit to the court the full scope of its September 4 policy reversal.

And what prompted that action early in September? It's no coincidence that mounting, NARD-initiated congressional criticism of HCFA's behavior was about to crest in a House Appropriations Subcommittee hearing scheduled for September 5. That subcommittee was to consider language drafted by NARD that would prohibit HCFA's attempts to confiscate pharmacists' earned discounts. In fact, subcommittee members were assured that HCFA would itself rescind its proposed policy change, and for that reason the subcommittee deferred consideration of the NARD-proposed language.

## Saving face

In all, pharmacy's victory is tarnished only by the recognition that HCFA/HHS behaved throughout in an arrogant, cavalier manner and repeatedly misled pharmacy and NARD. This behavior is all the more distressing in light of the fact that NARD has for several years worked closely with the government to develop an equitable drug reimbursement system.

### NARD's success in delaying the original January 1 target date saved pharmacists millions

A comment by the groups' lead attorney in the litigation, made in the motion to withdraw the suit, sums up pharmacy's frustrations. "Defendants failure—indeed their repeated failure—to communicate the rescission of the federal formulas put plaintiffs and this court to the burden and expense of litigation. Plaintiffs believe that they and this court have a right to expect better of the government."

We've reproduced the bulk of a declaration by high-level HCFA official Gale Held to the federal district court that details the agency's reversal in its attempts to force the policy change on the states.

I, Gale Held, declare:

Since June, 1984, I have been chairperson for HCFA's work group that developed the EAC initiative which has focused specifically on examining the levels of reimbursement that states employ for prescription drugs under the Medicaid program. Under my direct control, the work group in part formulates HCFA operational policy concerning implementation of certain aspects of prescription drug reimbursement under the Medicaid program.

On September 4, 1985 there was a conference call between senior central office HCFA officials and the ten Regional HCFA Administrators to discuss HCFA's policy nationwide on the actions it expected to take with respect to states' prescription drug pricing practices. During that conference call I made several points to make sure that all ten regions were following a uniform policy on this issue, a policy that had been agreed upon by senior HCFA management. First, there was to be no set deadline by which states had to alter their drug reimbursement methodologies if they were currently using the AWP standard, and that the October 1 deadline previously adopted by some regional officials was expressly rescinded. Second, I made it quite clear that states were to be free to develop and adopt any method of drug pricing that resulted in a more accurate reflection of providers' costs since no specific methodology developed at the federal level was mandated for state programs. Third, there was to be no target level for reductions in prescription drug costs. Fourth, the only firm deadline that we wanted regional officials to meet was to get together with state program officials by October 1, 1985 to discuss drug reimbursement practices and to encourage states to examine their own programs to see if more accurate drug pricing was possible. It was unmistakably clear to me that this policy was clearly understood by all regional officials, all of whom agreed to implement the approach outlined to them immediately.

### HCFA's persistence forced seven associations to file suit

On September 9-11, 1985 there was a conference in Chicago which I attended to bring together all regional staff personnel in HCFA who have been working on the EAC initiative. At this session, the same

(continued on page 88)

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direction previously given to the Regional HCFA Administrators was given again and was specifically stressed as HCFA's operative policy on this issue.

**Government officials failed to inform pharmacy lawyers that the policy had been rescinded nearly two weeks before the suit was filed**

The policy decisions of the agency described above continue to be fully in force throughout the nation.

On September 17, 1985, at the direction of central office HCFA officials, a model letter was sent to all regional offices to then be transmitted immediately to states, a copy of which was provided to the court in conjunction with defendants' opposition to plaintiffs motion to shorten the briefing schedule in this case. We sent the letter in order to clear up inconsistencies or errors in policy that may earlier have been implied by some regional officials to states. The thrust of the letters was to advise states that they should examine their drug pricing methodologies with an eye toward developing procedures that would reflect a more accurate picture of what providers in their states were truly paying for prescription drugs. We expressly wanted to dispel the notion that states were required to adopt any particular methodology to achieve the objective of a more accurate drug pricing methodology.

Perhaps foremost in our minds was an intention to rescind the October 1, 1985 "deadline" for states to make potentially needed changes in their reimbursement practices. For this reason, we expressly deleted the reference to October 1, 1985 that had erronously appeared in some regional HCFA correspondence earlier and had every intention to have this letter supersede all previous communications to states on this issue. While states were, and are, obviously free to make whatever lawful changes they deem appropriate concerning drug reimbursement practices in their programs, the point of the letter was to assure them that there was no requirement that they do so by October 1, 1985.

**HCFA's policy reversal came one day before a House Appropriations Subcommittee was to consider NARD-propsed language prohibiting the policy change**

In accordance with 28 U.S.C. 1746, the undersigned declares and certifies under penalty of perjury that the foregoing is true and correct.

In her comment to the plaintiffs in pharmacy's lawsuit, the lead attorney noted that the Held declaration "is everything we could ever have hoped to get." On the earned discounts issue, that's true. But as far as the government's behavior in the matter is concerned, there's lots of room for improvement. However, whenever the interests of independent retail pharmacy are at stake, NARD will be there—*accepting the challenge.*

Mr. RECTOR. This was an issue addressed by the Appropriations Committee 2 years ago. It was rejected. It should be rejected again.

The discounts that the pharmacies earn with their wholesalers are based on a whole host of incentives for prompt payment, for prudent purchasing, and a lot of other sound businesses practices. To do as GAO intimates in part, but as the Blue Cross/Blue Shield seems to say fairly specifically, confiscate those discounts would be counterproductive in any circumstance, but particularly in this circumstance.

We hasten to add that so long as our costs are going to be controlled and our prices are going to be set, I think you have to take a long and careful look at the prices of the manufacturers, at the participants of nonprofits hospitals in the program who have an acquisition cost base quite different from ours, and at the participants of nonprofits whose acquisitions cost bases are radically lower than AWP.

In all due respect to the witness from Blue Cross/Blue Shield, or for that matter, those that run the EDS and others—that have 12 percent net profit in running the Medicaid programs and similar net profits in running Medicare—and compare that with retail pharmacies that have an average of 2.8 net profit, I think you ought to explore with them in greater detail what level of net profit they expect from administering the Stark-Waxman Medicare outpatient drug coverage program. We think it should be comparable.

Thank you very much.

[The statement of Mr. Rector follows:]

# STATEMENT OF JOHN M. RECTOR
# BEFORE THE HOUSE WAYS AND MEANS
# SUBCOMMITTEE ON HEALTH

JUNE 2, 1987

Mr. Chairman, Members of the Subcommittee*:

I am John M. Rector. I serve as General Counsel and Vice President of the National Association of Retail Druggists.

The National Association of Retail Druggists represents the owners of nearly 30,000 independent pharmacies, where more than 75,000 pharmacists dispense 70 percent of the nation's prescription drugs. Together, they serve 18 million persons daily and provide 82 percent of Medicaid pharmaceutical services. Over 60 percent of NARD's members provide home health care pharmacy services. NARD has long been acknowledged as the sole advocate for the proprietary and professional interests of this vital component of the free enterprise system.

NARD members are primarily family businesses. They have roots in America's communities. The neighborhood independent druggist typifies the reliability, stability, yet adventuresomeness that has made our country great.

As owners, managers and employees of independent pharmacies, our members are committed to legislative and regulatory initiatives designed to provide them a fair chance to compete. We appreciate the opportunity to appear before the Subcommittee to present recommendations to be considered in the fashioning of Medicare Part B outpatient drug coverage.

We believe that a major strength of the health care system is the thousands of independent community pharmacies readily accessible to virtually every segment of the population. Any revisions in the Medicare program should capitalize on the strengths of the existing retail distribution network for drugs, and related products and services.

Competition in retail pharmacies is alive and well. Competition is an incentive for efficiency and the price competition in retail pharmacy is typically greater than can be found among other providers of health services and products.

We approach the subject of today's hearing with considered reluctance. Not because we oppose the concept, in fact we support it. Our statement of positions addresses it as follows:

> "NARD supports the position that any national health insurance program adopted by the Congress include outpatient medications as an integral part of its benefits. Patients participating in these programs also must be ensured that they will have the right to select the pharmacist and pharmacy of their choice to obtain their prescription drugs. Pharmacies providing prescription medications should be compensated on the basis of the marketplace price for such products and services. Independent retail pharmacists should be assured a key role in the planning and development of any such drug program."

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* Fortney H. Stark (D-CA), Chairman
MAJORITY: (7-D) Representatives Stark, J.J. Pickle (TX), Beryl Anthony, Jr. (AR), Brian J. Donnelly (MA), William J. Coyne (PA), Sander M. Levin (MI), Jim Moody (WI)
MINORITY: (4-R) Representatives Willis D. Gradison, Jr. (OH), Hal Daub (NE), Judd Gregg (NH), Rod Chandler (WA)

The source of our caution is predicated on the less than favorable experience that our members have had from the outset with the non-statutory Medicaid prescription drug program, and in recent years with the home health components of the Medicare program. We are concerned that a Medicare outpatient drug benefit program not replicate unsatisfactory aspects of the current Medicaid prescription drug program. Likewise, with more than 60% of our members involved with Medicare home health, it is critical that an outpatient drug coverage benefit be designed in a manner that will avoid the scandalous failure of Medicare to pay its participating providers in a timely, business-like manner, and avoid the constant barrage of arbitrary and inconsistent regulations dictated by HCFA.

More sophisticated aspects of program design become secondary, or even irrelevant, if when operational, appropriate resources are unavailable or if, as has been the policy of the current Administration, the government refuses to pay its bills promptly. Additionally, program continuity and stability is vitally important.

Fortunately, these especially severe Medicare cash flow problems, caused by the failure of HCFA and its agents to make timely payments, were addressed in the Omnibus Budget Reconciliation Act (OBRA) of 1986 by requiring that claims submitted for Medicare Part B Services be paid within 30 calendar days in FY 1987, 26 days in 1988, 25 days in 1989, and 24 days in FY 1990 and in subsequent years. We strongly support the Subcommittee's initiatives on prompt payment, and as a member of the Prompt Payment Coalition, urge you to oppose all efforts to repeal the 1986 amendments.

This past October our House of Delegates unanimously passed a resolution calling for the establishment by law of the Medicaid prescription drug program reforms it has been advocating for more than a decade. Its full text is as follows:

> WHEREAS, Congress never intended that the normal business practices of retail pharmacy such as earned discounts or marketplace pricing be placed in jeopardy, such as under MAC, EAC, PhIP and CIP, when a pharmacist serves patients in the Medicaid program; and
>
> WHEREAS, the concept of a government discount, whether in the form of a discount off ingredient cost or a total charge, is totally unacceptable:
>
> BE IT RESOLVED that NARD continue to oppose the concepts of a discount and instead, together with a coalition of pharmacy practitioners wholesalers, manufacturers and physicians, support the establishment by law of (1) marketplace pricing at the 90th percentile, and (2) a direct payment voucher system to reduce Medicaid administrative costs and assure prompt payment.

The two core themes of suggested reform: marketplace pricing and a direct payment system to reduce administrative costs and help assure that prompt payments are universally supported within the industry. In fact, National Association of Chain Drug Stores, Pharmaceutical Manufacturers Association, American Society of Hospital Pharmacists, American Pharmaceutical Association, National Wholesale Druggists Association, American Society for Consultant Pharmacists, and NARD all endorsed a document, "Principles for Reform of Medicaid Payment for Outpatient Drugs" in correspondence to HCFA's Administrator Roper on May 26, 1986. The principles, in our view, are equally applicable to the subject of today's hearing. Unfortunately, the Administration has not embraced them. We have provided the subcommittee with extensive information on these core ideas, including the NARD\Pracon study Marketplace Economics -- Alternatives in Medicaid Prescription Reimbursement (Oct. 1986). The full text of the "principles" follows:

# PRINCIPLES FOR FEDERAL REFORM OF PAYMENT FOR OUTPATIENT DRUGS

Following the implementation of the Medicaid program in 1965, pharmacists, more than other provider groups, enthusiastically supported and participated in this important health care program for the needy. Ten years later, in 1975, the Federal government adopted the Maximum Allowable Cost/Estimated Acquisition Cost program. This controversial approach established a complex set of formulas that imposed artificial controls on the retail marketplace and interfered with professional judgments regarding the selection of prescription drug products provided to the poor. In more recent years, the Medicaid program has been moving toward a reimbursement scheme that would further reduce reimbursement to pharmacies.

The Federal government seems content to capture limited, short-run savings at the expense of retail pharmacy providers and the research-intensive pharmaceutical manufacturing industry, while ignoring significant opportunities for reducing health care costs by allowing the competitive marketplace to function efficiently and effectively. In response, many prominent national organizations representing all components of the nation's drug distribution system--pharmaceutical manufacturers, drug wholesalers, independent pharmacies, chain drug stores, hospitals and the pharmacy profession--have been advocating a complete overhaul of the Medicaid drug reimbursement system. These organizations are calling for less government intrusion, so that the nation's pharmacies can continue to provide the highest standard of care and service to needy people.

## FUNDAMENTAL PRINCIPLES

Reduce needless federal regulation. American society experienced a virtual explosion in Federal Government regulation during the past decade. Between 1970 and 1979 the number of pages published annually in the Federal Register nearly tripled and the number of pages in the Code of Federal Regulations increased by over two-thirds. The current Medicaid drug program was part of this growth.

Although well-intended when originally developed, the Medicaid drug program has failed to keep pace with rapid changes in health care delivery over the past ten years. This has resulted in pharmacy providers subsidizing the Medicaid program because they frequently lose money when they fill a Medicaid prescription. Moreover, the hardship and uncertainty imposed on business by this over-regulation has impeded business decisions and expansion plans, ultimately reducing economic growth and the creation of jobs in the private sector. This over-regulation is particularly burdensome to small and independent businessmen and women, such as pharmacists who are proprietors of community pharmacies, and causes them to defer or terminate plans for expansion.

Our position on Medicaid drug reimbursement is directed at minimizing governmental intrusion by reforming or eliminating regulations which are unnecessary and counterproductive.

Improve administrative practices. Approximately 171 million claims are processed each year by the Medicaid program. Wasteful administrative overhead consumes resources that should be targeted on the health needs of beneficiaries. Furthermore, current inefficient administrative practices impose needless hardship on retail pharmacies due to slow and erratic payment and excessive paperwork. Initiatives to improve administrative practices can reduce both public and private costs to process Medicaid claims, and insure timely payment to pharmacies.

Rely on the marketplace. We do not need excessive Federal regulation to solve the problems of Medicaid drug costs. As long as we let the forces of the marketplace work without undue interference, the ingenuity of consumers, businesses, producers and inventors will do that for us. The retail drug market is dominated by self-pay customers who, along with increasingly cost-conscious third party payers, impose competitive discipline on marketplace prices. If we allow it to, the magic of the marketplace will unleash new competition, giving the Medicaid program lower prices, and Medicaid beneficiaries more choices and better services.

*To achieve meaningful reform, public policies governing the Medicaid drug program should be revised along the following lines:*

- *Base drug reimbursement on sound economic principles through the elimination of artificial controls. This would be achieved by replacing the current provisions governing reimbursement with marketplace pricing, i.e., usual and customary charges for all products and services, capped, for example, at the 90th percentile for all charges within a state.*

- *Implement a new and streamlined reimbursement mechanism that would greatly lower administrative expenses in the program. Such a worthwhile objective can be easily accomplished by coupling marketplace pricing with an innovative system of drug vouchers.*

*States shall build upon this basic set of principles established by the Federal Government, tailoring their individual programs to fit local circumstances.*

## ADDITIONAL RECOMMENDATIONS

Additionally, we recommend that the subcommittee seriously consider the following:

a) The reinstatement of the 60 day or longer public notice for changes in the Medicare reimbursement method or level of reimbursement for the prescription drug program;

b) Interest and penalties for late payments;

c) An administrative fee for the extra cost of processing or transferring Medicare forms;

d) Inclusion of both short and long term I.V. antibiotic products and services;

e) Require and reimburse for pharmacist consultation. Face to face communication between patient and pharmacist has been a vital component of pharmacy practice since its inception. Pharmacists interact daily with patients in their stores; they monitor their patients' health status, assess their compliance with drug therapy, answer questions, make recommendations, and communicate with their physicians. Patients know they can count on the pharmacists to provide expert advice on drug therapy on the spot and personally attend to their individualized health care needs. This interpersonal communication is an especially key element for Medicare eligible persons.

f) Reject suggestions to confiscate the discounts that pharmacists earn. Discounts extended to pharmacists on drug purchases from manufacturers or wholesalers as rewards for prompt payment, prudent purchasing, and other sound business practices are an earned portion of the pharmacist's business income. Such discounts are earned by pharmacists for operating their businesses efficiently. They serve as incentives to help a business to prosper and to continue to serve patients in the community.

g) If copayment is established, require that it be mandatory. More than 60% of our members' sales are for prescription drugs, 10-15% of our members sell only prescription drugs. They rarely "loss lead" prescription drugs and would be placed at a decided competitive disadvantage if the copay is not mandatory. Equally problematic are the copay forgiveness aspects of the Medicaid program for select beneficiary groups.

h) To address the problem of tax-exempt competitors, consider adopting provisions similar to OMB Circular A76 for bidding on federal contracts which, to assure a level playing field, requires the advantages of nonprofit status to be reflected. This should be reflected in reduced payment to any eligible nonprofits.

i) Require that manufacturers eliminate multitier pricing policies for prescription drugs, or in the alternative, permit independent retail druggists to acquire for Medicare purposes the drug products under the same pricing structure available to non-profit entities.

j) Review the present reimbursement for prescription drugs under Medicare Part A with an eye to determining present cost to the government in contrast to cost in the prescription drug retail marketplace.

k) Consider, as the Energy and Commerce Committee has recommended in its Oversight Subcommittee Report "Dangerous Medicine"(May 1986), denying Medicaid and Medicare funds to hospitals and other health care institutions convicted of diverting prescription drugs.

l) Consider a provision to assure that nonprofit purchasers of prescription drugs utilized in the Medicare programs comply with the 1938 Nonprofit Institutions Act. This Act permits price discrimination for purchases by true charities. We recommend that an appropriate standard would be the percent of uncompensated care provided by the nonprofit entity coupled with bad debt.

m) Include a provision that would limit physician dispensing to rare rural remote circumstances when it can be demonstrated that a pharmacy is not available. Prescription drug samples which were retained under the provisions of H.R. 1207, (which passed the House of Representatives on May 4, 1987, after having been unanimously reported by the Energy and Commerce Committee and this subcommittee) are available for any true emergency when a 24-hour pharmacy emergency number, which is common, is not available.

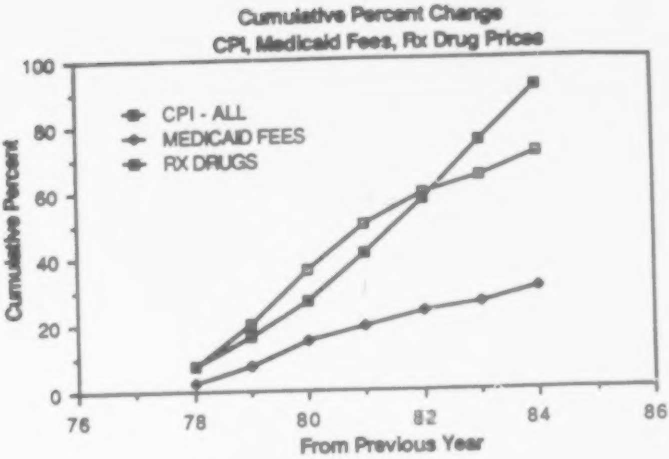
n) Consider the profit guaranteed to entities that are awarded contracts to administer state Medicaid prescription drug programs and Medicare fiscal intermediaries when attempting to establish an appropriate level for pharmacy providers.

o) Consider the prescription drug benefit program that Marion Laboratories, Inc., Kansas City, Missouri, has established for its employees. It is based on marketplace pricing and rejects the cumbersome arbitrarily fixed dispensing fee. It reflects the variety of professional services, and importantly, it has helped contain the cost of the prescription drug benefit coverage that Marion established for its employees.

## INITIAL COMMENTS ON MEDICARE CATASTROPHIC PRESCRIPTION DRUG LEGISLATION OF 1987

We have attempted to assess the draft legislation as expeditiously as possible. We do expect to file more detailed comments with the subcommittee and its staff. We support the subcommittee's effort to provide appropriate Medicare outpatient prescription drug coverage and would characterize this legislation, as we have that developed by the Chairman of the Health Subcommittee of Energy and Commerce, namely, a giant step forward.

We cannot stress too much, however, our very real concerns that the shortfalls and disasters for providers, especially under the non-statutory laissezfaire Medicaid program, not taint the excellent opportunity which the subcommittee has to address the drug needs of the elderly. The following chart effectively demonstrates one of the major problems our members have experienced under the Medicare Prescription Drug Program.



In 1977 the average unweighted dispensing fee for all states was $2.46. This fee had increased to $3.21 in 1984, representing an increase of only 30.4 percent for the eight year period. During this same period, the Consumer Price Index for all items had increased 71.2 percent, and the cost of prescription drugs to the consumer increased 91.2 percent.

*"Pricing of Pharmaceuticals: An Independent Community Pharmacy Perspective" by D.C. Huffman, Jr., Ph.D., et al. Presented to the Second Annual Conference on Pharmacy Policy Issues at the Hubert Humphrey Institute, University of Minnesota, 1987.*

We have three general observations which are made in a constructive vein, each of which relate to the need for fundamental fairness in whatever program is designed. Although we prefer a marketplace pricing standard, if the subcommittee is intent upon setting our prices, you must address the prices of others participating in the program over which the pharmacist has no control.

1) We have no control over manufacturers' prices. Manufacturers could be required to submit prices to the Secretary twice a year in conjunction with the "calculation period", e.g. October 1/April 1. They would guarantee such prices for that period, just as is the case presently for Medicare inpatient prescription drugs. We should not continually take a bad rap from the public, especially the needy and elderly, for the price of prescription drugs over which we have no control.

2) Hospital reimbursement for inpatient prescription drugs under Medicare similarly should be on the same terms as Medicare outpatient drugs. If, as your draft legislation does, cost-plus based reimbursement is rejected for outpatients, it should be rejected for inpatients and comparable cost-control mandated for the hospital setting, for example, average wholesale hospital cost (AWP).

3) Likewise, those entities which would administer the Medicare outpatient drug program should be subjected to comparable cost controls. Such criteria should be specified in the determination of the actuarial rate.

Among our specific legislative comments on your proposal are the following:

1) We support the 20% co-insurance cost-sharing provision.

2) Regarding the $4.50 administrative allowance, we recommend the automatic annual application of the CPI.

3) A national formulary could prove to be complex and costly to operate. In any case, the details of the formulary should be, to the extent possible, expressed in the statute and/or the committee's accompanying reports. Additionally, it's important in our view, that the Secretary be required to consult with individuals of recognized professional standing and distinction in the fields of medicine, pharmacology and pharmacy. In fact, if a national formulary is established, it is essential in our view that a statutory formulary committee be set up that would establish the appropriate involvement of such individuals.

4) We support the provision which would require electronic billing by 1991, except in rural areas. Perhaps the definition of rural recently developed in conjunction with the authorization increasing the speed limit to 65 m.p.h. would be appropriate.

5) We recommend that Medicare payment be limited to a 34-day supply or 100 dosage units, whichever is greater. Recent studies, including that by the Pharmaceutical Data Services, documented the phenomenon known in the trade as "wastage" -- the percentage of prescription drugs filled but not used when more than this supply is authorized. The International Ladies Garment Workers Union is typical of the plans which permit its members to buy only a 30-day supply because of wastage.

It's important to emphasize that the national Pharmacy Services Administrative Organization (PSAO) movement and other developments have brought independent pharmacies to the point that the recordkeeping required to monitor expenditures by Medicare beneficiaries is readily achievable.

## CONCLUSION

NARD seeks the support of the subcommittee for our recommendations and will assist its members and staff in the refinement of your proposals. Additionally, it is our intention to submit a supplemental statement to the subcommittee addressing several other aspects of this legislation.

On behalf of the Officers, Executive Committee, and members of the National Association of Retail Druggists, we thank you for the opportunity to appear and continue to participate in the formulation of Medicare Part B outpatient prescription drug coverage.

Chairman STARK. Thank you.
Mr. Donoho?

## STATEMENT OF PATRICK DONOHO, DIRECTOR OF GOVERNMENT AFFAIRS, REVCO D.S., INC., ON BEHALF OF THE NATIONAL ASSOCIATION OF CHAIN DRUG STORES

Mr. DONOHO. Thank you, Mr. Chairman. I am Patrick Donoho. I am director of government affairs for Revco D.S., a corporation that operates over 2,000 pharmacies in 30 States. I am appearing today on behalf of the National Association of Chain Drug Stores and our comments this afternoon are based on a draft outline we got from staff.

I would like to say that we are really encouraged by the direction of this outline, but that encouragement is all predicated on adequate funding.

As you know from our testimony at the last hearing, we are not enamored by the State Medicaid program's reimbursement structure. We believe a better structure could be designed. We urge you to include demonstration projects on reimbursement structures and processing systems for pharmacy providers in your bill.

In this way we will be able to demonstrate the virtues of the retail market system on prescription drugs and also I hope we will be able to develop a better system for delivery and payment of prescription drugs to the catastrophically ill.

We would like to make the following suggestions regarding specifics contained within the outline. No 1 is the deductible. We support the use of a high deductible which is indexed. However, the mechanics and implementation of the deductible need to be explored and resolved before passage of the legislation. We recommend that the Medicare program issue and embossable eligibility card to recipients after they have met the deductible, and reimburse the recipient directly for any prescription dispensed between the time they applied for meeting the deductible and receiving their eligibility for benefits card.

The determination of meeting the deductible should be the responsibility of the Medicare administrator and not the pharmacy. Our experience with the United Mine Workers program in West Virginia highlights the need for these issues to be settled and clear. Angry mine workers have been known to show up at retail pharmacies with a fist full of receipts and a six-shooter and say, "I met my deductible, now give me the copayment."

The second point is on copayments and coinsurance. We support the inclusion of coinsurance. My company knows from our experience with over 500 prescription drug plans that consumer participation in price determinations is extremely critical to cost containment. A system of coinsurance will provide incentives for consumers to use generics, prudently shop, and control the utilization.

No. 3 is on reimbursement. Because of our experience with the Medicaid program, and to a limited degree, the Medicare program, we would strongly urge that Congress require prompt payment. If the carriers are unable to meet this requirement, they should be required to pay interest on the unpaid claims.

In addition, we would suggest a reasonable administrative handling fee to cover the cost of participation. Some State Medicaid programs already provide this to cover such things as interest on accounts receivable and claims processing charges, and we urge your consideration of adding this provision. We applaud your effort in having the dispensing fee indexed to a standard. We pledge our support to you in developing proper and fair criteria for such an index.

No. 4 is generic drugs. Provision should be made in the bill to clarify the role of this program vis-a-vis the State substitution laws; either the State substitution governs the use of generics, or a preemption of such statutes with a strong Federal standard.

Without resolution of this problem, such issues as a two-line prescription form, formularies and other requirements could place a pharmacist in a tenuous position when participating in this program.

We would also like to suggest that the limit of reimbursement for substitutable generic drug products be based on a percentage of the innovator or brand-name product indexed to the CPI for multisource products where there are three or more generic manufacturers. In this way a percentage savings vis-a-vis the brand name products is ensured and we believe adequate levels for availability would be set.

We are concerned about the availability of products set at the lowest AWP of a manufacturer. The pharmaceutical manufacturing industry is rapidly changing and such a requirement could be affected by marketing practices of a particular company. We respectfully request to have the record remain open so that we may be able to provide greater information on cost savings with generics.

Lastly, the formulary. The outline is not clear regarding the formulary determinations, and also its interaction with the deductible. Specifically, if an elderly person is on Feldene and is using this product to meet the deductible, would they have to change products if Feldene was not covered by the formulary? Would they be required to change a product within the same therapeutic class, generic class, or some other standard?

How often would this formulary be updated? Members of our association have been involved in the establishment of formularies both private and public, and we offer their expertise to you.

The administration of the program is another concern. We believe that electronic billings and claim processing is a must in any program. However, it could be similar to the difference between owning a Chevette and a Cadillac. They are both made by GM. They are both cars, but are very different.

Demonstration projects would be an excellent opportunity to test new technologies in this arena. Such ideas as direct patient reimbursement, dollar caps, or other structures could be studied. Hopefully, you will give serious consideration to developing such pilot programs in conjunction with the provider community and recipients.

One slight technical question in the administration area is with the days supply limitation that was raised before. We would hope that State law would preempt in that arena.

Thank you for the opportunity to testify.

[The statement of Mr. Donoho follows:]

# Statement of the National Association of Chain Drug Stores, Inc.

BEFORE THE HOUSE WAYS AND MEANS COMMITTEE

SUBCOMMITTEE ON HEALTH

OUTPATIENT PRESCRIPTION DRUG COVERAGE UNDER MEDICARE

June 2, 1987

NACDS
National Association of Chain Drug Stores, Inc.
P.O. Box 1417-D49
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703-549-3001

## INTRODUCTION

Mr. Chairman and Subcommittee Members, the National Association of Chain Drug Stores, Inc., (NACDS) appreciates the opportunity to testify on the issue of an outpatient drug benefit under Medicare.

NACDS is a non-profit trade organization, founded in 1933, which represents the management of 171 chain drug corporations that are operating close to 20,000 retail drug stores and pharmacies throughout the United States. Collectively, our members were responsible for $30 billion in retail sales in 1986 and more than 540 million prescriptions were dispensed to patients by corporate drug chains during this same period. Also, 50,000 pharmacists practice their profession for our member companies.

This morning, our statement will once again present our views on what the chain drug industry sincerely believes to be the essential ingredients for a drug benefit coverage under Medicare in terms of scope, reimbursement and administration. Essentially, our recommendations reflect the same sound principles that NACDS and its corporate members have previously advocated to Congress and the Administration during 1986 and this year on reforming and improving drug reimbursement policies for Federally assisted health care programs, such as Medicaid and Medicare.

To a great degree, we are recommending that Congress abandon bad public policy fashioned some 15 years ago and embrace a new approach that recognizes emerging technology and promotes competition while harnessing opportunities for cost savings through a greater emphasis of generic drugs. NACDS does not put complete faith in the notion that generics are the end-all solution for savings, but we do believe that greater generic utilization is necessary to balance future program costs in anticipation of ongoing price increases by brand-name manufacturers. As evident by the Congressional hearings held in April of 1987, the House Energy and Commerce Subcommittee on Health found that although the Consumer Price Index (CPI) only rose 2.7 percent since 1985, pharmaceutical manufacturers' prices jumped 12.2 percent. Thus, in our opinion, generics will need to play a major role in the Medicare program in order to offset predictable brand-name cost increases in the coming years.

Regarding the specific issue of providing outpatient drugs under Medicare, we strongly support adding this benefit and it is our position that all prescription drugs should be included under Medicare Part B. We further believe that the competitive marketplace is the preferred and most cost-efficient system for delivery of drug benefits to the elderly.

### Retail Pharmacies -- Competitive Marketplace

In our view, Congress must proceed carefully in fashioning Medicare Part B Drug Coverage and develop components that are compatible with the retail market. Unlike other health care benefits, the vast majority of the payors of pharmaceutical services are actually the consumers of such services. This provides a strong incentive for consumers to seek out and shop for the best value for their money and induces retail pharmacies to meet the general public's price/value needs. As an industry, NACDS estimates that more than 70 percent of all prescriptions filled by chain drug stores are dispensed to consumers who pay cash for their medications. Keep in mind that there are close to 60,000 retail pharmacies in the United States engaged in intense competition for this business. In fact, competition has greatly intensified in recent years with mass merchandisers, food chains, HMO's and mail order joining a crowded field to fight for marketshares that have been traditionally the sole domain of independents and drug chains. The benefits of such competition are readily apparent as consumers are now being aggressively courted by price comparison ads, expanded services and computerized records and other inducements.

Recognizing the highly competitive nature of the retail drug business, NACDS strongly recommends that a reimbursement system for outpatient drugs under Medicare should adopt a marketplace approach for payment. We, therefore, support reimbursement that is based on marketplace pricing which is the retail pharmacy's actual price capped at the 90th percentile of all charges for the same prescription. A further refinement of this sound concept is a modification of the Health Care Financing Administration's (HCFA) own Competitive Incentive Program (CIP) proposal which embraces marketplace pricing. Under this approach, generic drugs would be reimbursed at the pharmacy's full marketplace price or actual price. Reimbursement for brand-name drugs that have three or more generic equivalents would be at the pharmacy's marketplace price capped at the 75th percentile of all charges within the state. We are certain that with a Federal policy which carefully and prudently differentiates between generics and their brand-name counterparts with respect to retail reimbursement rates, there will be a greater economic incentive for pharmacies to dispense generic versions when permissible and possible.

Regarding non-multiple source drug products (i.e. sole source drugs or products which have fewer than three suppliers) these items would be reimbursed at the marketplace price capped at the 90th percentile. By the same token, if the doctor insists on the brand-name drug -- as medically necessary -- it would be paid for at the 90th percentile. In our opinion, this reimbursement approach will provide for a more balanced treatment of brand-name and generic drugs than we currently have under Medicaid and significant savings can be achieved.

Beyond our strong endorsement for marketplace pricing as the basis for reimbursement, NACDS believes that consumer participation in cost containment is critically essential. Therefore, we support the use of a high deductible for prescription drugs and a system of direct patient reimbursement. This is very similar to present major medical plans which allow for prescription drugs to be considered as part of the deductible. The strength of such a system is that the consumer maintains an incentive to shop prudently for the best prescription price before and even after a deductible is met. As such, competition and efficiency are continually enhanced.

## ELECTRONIC DEBIT CARDS

Additionally, with consumer participation as a major feature in a legislative approach to establish outpatient drug coverage under Medicare, Congress can take this important health care benefit to its next logical step by tapping into a new innovative processing system using electronic debit cards. This technology expands the realm of possibilities for prescription drug reimbursement that can be successfully tailored to the retail marketplace. Such innovative ideas as diagnostic related groups for drug products (for example, we can determine average drug costs for treating arthritis); dollar caps on reimbursement per recipient, variable co-payments which would reflect a percentage of the prescription price and other new approaches become more feasible and advantageous under an electronic process system. For example, case managing of a patient would be ideal and would make the administration of such a benefit run smoothly and efficiently.

Further elaboration of the benefits and advantages of the electronic debit cards are succintly presented in a recent article, dated May 23, 1987, which appeared in the National Journal. We have attached this interesting story to our testimony because of its relevancy to the issue of a drug benefit program not only for Medicare but for Medicaid as well.

## NACDS VIEWS ON CHAIRMAN STARK'S LEGISLATIVE OUTLINE

With respect to the specific provisions of the outline draft developed by Chairman Stark, we offer the following comments. In general, we support the approach and the $500 annual deductible, including the indexing of the deductible to increases in drug costs. NACDS also favors the inclusion of cost-sharing in the draft, and we believe that the 20 percent co-insurance requirement is a very important aspect. We urge that the co-insurance be determined based on a drug store's marketplace price or actual retail charge for both brand-name and generics. Our members further recommend that the Congress make the collection of the co-insurance mandatory. And it is the position that this proposal should clearly indicate a system of direct patient reimbursement.

Additionally, our corporate members are encouraged that the outline draft boldy calls for marketplace pricing (actual charges) as an important parameter to determine reimbursement levels. Regarding payment for prescription drugs, we recommend that there needs to be a definite reference for prompt payment such as payment to the pharmacy by the carrier of 90 percent of all valid claims within 30-days. We would also urge the inclusion of a reasonable administrative handling fee for those brand-name drugs that are reimbursed at actual charges. On the outline's provisions relating to payment for generic drugs, our corporate members suggest that the so-called "lower-of" provision concerning 125 percent of AWP of the lowest cost generic drug brand plus a dispensing fee be revised. We recommend that this language be changed to "50 percent of the AWP of the equivalent innovator product based on what is substitutable under state law when there are at least three sources of supply. When there are less than three sources of supply, generics should be reimbursed at 125 percent of AWP plus a $4.50 dispensing fee. In terms of the outline's impact on state generic drug laws, we urge that the outline pre-empt those laws or allow them to prevail. In other words, Congress should not create another standard regarding substitution.

NACDS strongly supports the provision in the outline that, in terms of the $4.50 dispensing fee, an indexing requirement is called for to reflect the cost of doing business in future years. We ask that the indexing requirement related to the dispensing fee apply to both brand-name and generic drugs. In terms of the formulary reference in the outline, we feel that this concept can be supported, but since the formulary description is vague, NACDS reserves the right to comment at a later date. For example, we are unclear as to how the formulary would interact with the deductible.

The chain drug industry believes that the administration of the program is best handled and managed through a uniform electronic billing system. We, therefore, support this important aspect of the outline and offer to share with the Committee how our corporate members currently conduct this type of billing. On this same issue of administration, however, we need to work closely with the Congress to develop reasonable guidelines to clarify the case management role that retail drug stores will play to assist patients who have met their deductible. Thus, we ask that a retail-carrier-senior citizens task force be established to iron out the mechanics for eligibility and case management to insure that the program works efficiently.

In summary, NACDS supports the overall approach that Chairman Stark's outline takes because it is well-balanced and fair to all concerned parties which means that a bill crafted in this fashion can move forward. In our preliminary endorsement of this compromise that would provide important drug coverage to the elderly, we offer several additional suggestions for consideration. NACDS asks the Subcommittee to develop a number of demonstration projects as part of the bill or thru the appropriations process to test the advantages and benefits of marketplace pricing which could encompass, among other things, a specific dollar cap per recipient and direct patient reimbursement. Our corporate members are prepared to help design such a system with a view toward having one standard for the nation. We believe that these demonstration projects are important to the issue at hand in terms of examining innovative ideas and NACDS recommends that the demonstration projects should coincide with a legislative review of the Medicare outpatient drug benefit three years from the effective date of the Act.

To conclude, we are in favor of the direction that Mr. Stark's outline is taking and urge that our comments on the various features of the legislation be given careful consideration.

Thank you.

TK/kar

**STATE OF THE STATES** Neal R. Peirce

# Has the Time Come for Credit Card Welfare?

ST PAUL—There's serious talk these days about legitimizing welfare, shifting it from a despised dole to a training-and-jobs program. But even more startling is the proposal to bring public assistance clients into the mainstream by letting them pick up their benefits at automated bank-teller windows.

"Credit card welfare" isn't a reality yet, but it may be soon if an experiment authorized by the Ramsey County (St. Paul) Human Services Department pans out.

And not just for welfare payments. "Electronic benefit transfer," as it's called, might just be a foot in the door to a single card that accesses every benefit from food stamps to medicaid to child support payments. "We're testing one thing, but we're thinking about a lot of things," acknowledged the county human services director, Thomas J. Fashingbauer.

> No one knows whether the poor will use automated bank-teller machines when only 40 per cent of U.S. bank customers use them.

Ramsey County's adventures into innovative financial services for the poor began with a crisis: Local banks, eager for upscale patrons, rejected the county's contract to cash welfare checks. The banks said there wasn't enough "float" to cover the expense of extra tellers or the harm to their image of having their lobbies packed with welfare mothers early each month.

Enter Truman W. Porter, an imaginative officer at Midway National Bank of St. Paul. Midway would set up a temporary special office to cash the checks each month. But the county, Porter said, would have to agree to take a serious look at electronic methods of distributing welfare benefits. The county agreed, became fascinated with the potential and decided on a pilot program. Midway, in consortium with the St. Paul-based TransFirst Corp., a wholly owned subsidiary of First Texas Savings and Loan of Dallas, and Minnesota's Norwest Bank Corp., won the contract.

The test starts on July 1. About 1,200 of the county's 14,000 welfare recipients will be issued plastic cards with photos and a magnetically encoded strip. They'll be given a secret number and an hour or two of training.

One group will get payments by using automated bank-teller machines. A second will be told to take its cards to designated stores where tellers, equipped with magnetic card readers connected to a central computer, will pay out benefits. A third group will have its choice of either method.

Will the poor feel at home using bank machines the general population often shuns? No one knows; so slow are many of us to accept new technology that even today, only 40 per cent of U.S. bank customers use automated-teller windows.

But if the experiment works, the county will save about $1 per recipient per month because it will no longer have to produce checks and mail them out.

Clients will not be stigmatized by having to go to special check-cashing locations often miles from home. They'll run less risk of being mugged as they leave with a bundle of cash; if they wish, in fact, they'll be able to receive their benefits in smaller chunks during the month.

Ramsey County isn't the first to nibble at the edges of credit card welfare. New York City, which once mailed out half a million welfare checks monthly, has shifted to plastic cards that recipients can take to about 350 specially designated check-cashing outlets. Food stamps are issued at the same locations. Reduced fraud and operating costs save the city $9 million yearly.

In Reading, Pa., there was a successful though costly experiment letting recipients draw food stamp benefits through debits registered on magnetic card readers in supermarkets or farmers' markets. Massachusetts, New Jersey and New York have implemented on-line medicaid authorization payments at hospitals and clinics with magnetic card readers.

But Ramsey County will be first in the nation to share the terminals used by regular banking networks. Carried to its logical conclusion, the system would allow all public assistance recipients to join the mainstream of statewide, eventually nationwide, electronic fund transfers. The only exceptions, one day, might be shut-ins who would continue to need checks.

All this makes grander visions dance in the head of banker Porter. He foresees a day when Americans will reject the idea of a thousand and one dedicated cards, for stores, oil companies, Visas and MasterCards, and demand one they can use for anything—from a charge or instant debit at a store to registering for college or drawing government benefits.

The obstacle to more efficient use, Porter said, isn't with the technology. It lies with public skepticism, with major institutions unwilling to cooperate, with credit card issuers preoccupied with their own marketing.

A leading advocate of a single tamper-proof ID system is the Rev. Theodore M. Hesburgh, departing president of the University of Notre Dame and recently chairman of the federal Select Commission on Immigration and Refugee Policy. "The average American," Hesburgh writes, "carries more driver's licenses, credit cards, check-cashing cards, medical insurance cards and employee IDs than the citizen of any other Western nation. But he or she has the least security against ID counterfeiting, forgery or fraud."

Whether or not the One Great Card awaits us all, the St. Paul experiment might well open some important doors, not only to the use of the same card for food stamps and medicaid, but perhaps even for day care vouchers as welfare systems are expanded to provide child care so that young mothers can move into jobs. All court-ordered child payments could be expedited the same way, from the debiting of one parent's account to the crediting of the other's.

The world of welfare lacks private firms clamoring to take control and sell their exclusive cards and systems. But if Minnesota's experiment pays off for banks, we might see an ultimate irony: models of convenience in financial services that are developed first for a welfare population and then are demanded by middle-class America. ☐

Mr. ANTHONY [presiding]. Mr. Allnutt?

## STATEMENT OF ROBERT F. ALLNUTT, EXECUTIVE VICE PRESIDENT, PHARMACEUTICAL MANUFACTURERS ASSOCIATION

Mr. ALLNUTT. Thank you, Mr. Anthony.

I, too, appreciate the chance to testify and to bring the views of this industry to this important issue.

Prescription medicines are a critically important component of the national health care system. Our industry strongly believes that all older Americans should be able to receive the medicines that they need and we welcome the efforts of this subcommittee to focus on the problems some elderly face.

The first few pages of my statement deal with some of the issues that I gather the chairman raised in his opening remarks this morning, and I will skip over those and perhaps come back to them when the chairman returns.

I will skip to the bottom of page 4. Available data demonstrate that the vast majority of Americans, including elderly people, are financially able to obtain drug therapy, but there are no reliable data defining the number of elderly who cannot obtain adequate therapy for financial reasons.

It is absolutely essential in our view to determine the size and characteristics of such a group of older persons before it can be determined how to design an appropriate and affordable program. I must say that some of the comments by the various pharmacy interests here at the table today indicate everyone says, well, maybe we ought to be doing this, but we do not like this part of it, and we do not like this feature of administration.

I think there are a lot of questions about how such a program would work, and the strongest proponents of the legislation, including the AARP, acknowledged in their testimony in May that very little data exist on the potential costs of these kinds of benefits.

There was a lot of discussion this morning and various estimates as to whether we or the committee or GAO or anyone knows what such a program may cost. I understand that CBO is to be called to testify later. That is certainly to the good. I would suggest that HCFA might also be called.

I have a table that we put together. I testified before Chairman Waxman's subcommittee this morning. We can make it available. Perhaps Mr. Anthony would like a copy.

Mr. ANTHONY. Do you want to make a copy of it available for the record?

Mr. ALLNUTT. Yes; I do. And let me just run through quickly what is there.

Mr. ANTHONY. Without objection it will just be added as an addendum to your testimony.

Mr. ALLNUTT. Let me just mention some of the numbers there. I understand that CBO says the annual usage per enrollee would be $200. HCFA has had various numbers. My table here says $300. A member of this subcommittee this morning told me that he thought it was $370.

The experience in the Pennsylvania PACE program is $400. That is an actual program, not an estimate. New Jersey pharmaceutical assistance program, $380; Medicaid itself, $368. AARP says there are $9 billion in drugs for the elderly in this country. If you divide that by the number of the elderly, that is $300. So you can go through these various numbers.

I think the kind of thing that the subcommittee would want to know is, what is likely to be reality? Similarly, with the percent of enrollees spending more than $400—this was for the Waxman bill, so not for the $500 that is in the chairman's outline—estimates vary. I understand the CBO number is 13.8 percent; 19.5 percent, the HCFA number. The actual number in the Pennsylvania PACE program is 30 percent.

So there really are wide disparities among the data, and I would suggest that I agree with your comments this morning, Mr. Anthony, that the subcommittee should look into what the estimates are likely to settle out at.

Moving on to page 6 of my statement in designing a program—and we do believe an affordable and adequate program can be designed—we list a number of characteristics we think the program should have.

The point in all of this, and the danger that we see in adoption of an entitlement program without really knowing what it is going to cost, is that when the costs exceed the estimates, as they almost surely will, we are led, inevitably, then to the kinds of proposals, some of which are already in some of the pending bills, for ways to cut back on the benefit—cut back on the cost of the benefit, or cut back on the benefit itself—thus, reversing course and denying those in need the very benefits that were intended for them initially.

We then list, on pages 7 and 8, some of the factors that we think ought to be considered and the kind of study that ought to be conducted, including the coming pressure on the Medicare fund overall, not only from the built in premium increase that is going into place in October, and for the increase that catastrophic coverage will bring. Also, as you heard from some of the witnesses this morning, the main concern of the elderly is for long term care coverage.

I think this subcommittee should not overlook what AIDS is likely to mean in the years ahead to the likely cost of Federal and State programs as they reach into the billions of dollars in the early 1990's.

I also mentioned a number of States—nine of them—that now have benefits for the elderly. There are six other States considering such programs.

Finally, let me just say a word about formularies, which several people have mentioned today. I would like to submit for the record a paper on the subject of formularies, including references to a number of studies. They do in the main, if not entirely, relate to studies of Medicaid programs, because that is where formularies are now. There are not Medicare formularies in existence. But I would not on my own see any difference between the effect of a formulary, be it Medicare or Medicaid.

The effect is to slow down the introduction of new drugs. If you look at the Medi-Cal formulary in California, the anti-ulcer medicine took 26 months from the time it was approved by the Food and Drug Administration until it was reimbursable under the Medi-Cal program. Other medicines have taken in some cases as long as 5 years.

What that means is the beneficiaries of the program are denied these new medicines while some bureaucracy sits and tries to decide whether they should be part of the program. That is why some States that have had such programs are abandoning them. Others are trying to take steps to speed up their process and cut the cost of them.

If you think formularies do not work well in the States, wait until there is some committee sitting down in the Humphrey Building trying to decide long after the Food and Drug Administration has approved a new drug, whether the people who are beneficiaries of this program should receive it.

Thank you, Mr. Chairman.

[The statement of Mr. Allnutt follows:]

ROBERT F. ALLNUTT
EXECUTIVE VICE PRESIDENT
PHARMACEUTICAL MANUFACTURERS ASSOCIATION

BEFORE THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

JUNE 2, 1987

Mr. Chairman and Members of the Subcommittee:

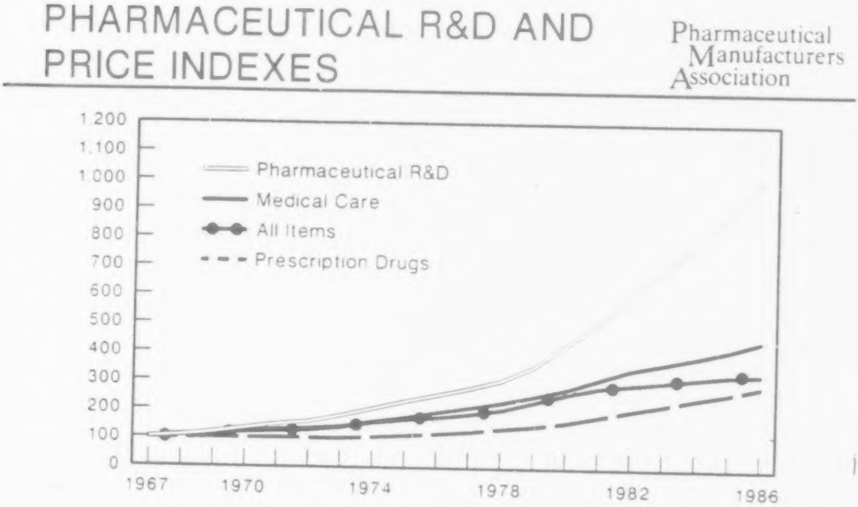
Thank you for the opportunity to appear before the Subcommittee to testify on Chairman Stark's proposal to cover the cost of prescription drugs for outpatients. PMA represents more than 100 research-based pharmaceutical companies that discover, develop and produce most of the prescription medicines used in the United States.

Prescription medicines are a critically important component of the national health-care system. Our industry strongly believes that all older Americans should be able to receive the medicines they need, and we welcome the efforts of this Subcommittee to focus on the problems some elderly people face.

The modern medicines our companies develop enable people to live longer, healthier and more productive lives. Drugs extend lives, cure illness and improve the quality of life for all Americans, especially the elderly. Indeed, senior citizens are among those who most use the medicines our companies discover and develop, and who benefit the most from these drugs.

Prescription drugs not only save lives--they save money. Prescription drugs are the most cost-effective form of modern therapy. They save billions of dollars a year by reducing the need for alternative, more expensive forms of therapy, such as hospitalization and surgery. The use of drugs also reduces the cost of physicians' services and the number of work days lost due to illness. One anti-ulcer drug alone, Tagamet, saved Americans an estimated $4 billion in health-care costs in its first decade on the market.

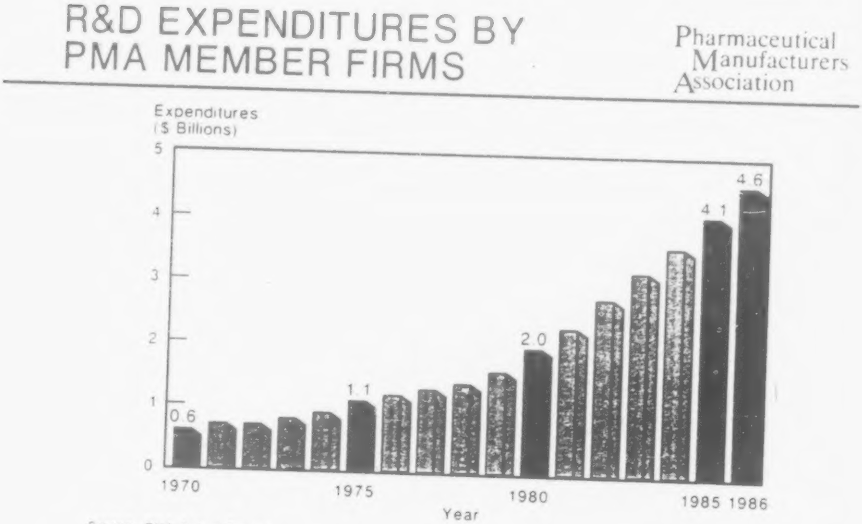
Even though prescription drugs are the most cost-effective form of therapy, they represent only a small portion of health-care expenditures. As a nation, we spend less than a nickel of each health-care dollar for outpatient drugs. Drug prices have remained well below the Consumer Price Index since that Index was established in 1967 (Figure 1). And the cost of drugs has actually declined in terms of purchasing power.



Source: Bureau of Labor Statistics, PMA

Figure 1

Every five years since 1970, the pharmaceutical industry has doubled its investment in research and development (Figure 2). This year, these companies are investing $5 billion in R&D, nearly equalling the total being spent by the National Institutes of Health for all biomedical research. The period of time during which this investment in R&D can be recovered through sales revenues, however, is being dramatically compressed due to a number of converging forces. Foremost among these forces is the unprecedented surge in competition from generic products as soon as the patent on the pioneer drug expires. Other major forces include the intense competition within the research-based pharmaceutical industry to develop and market new patented drugs; increasing delays in the approval of new drugs; and increasing foreign competition both from developed countries that have targeted this industry and from newly industrialized countries that blatantly condone patent piracy.



Source PMA Annual Survey

Figure 2

It is because prescription drugs are necessary to ensure that all people receive the very best health care and because they are the most cost-effective form of health care that the industry believes older Americans should have access to the full range of prescription drugs.

Available data demonstrate that the vast majority of Americans, including elderly people, are financially able to obtain drug therapy. At this time, however, there are no reliable data defining the number of elderly people who cannot obtain adequate drug therapy for financial reasons. It is absolutely essential to determine the size and characteristics of such a group of older persons before it can be determined how to design an appropriate--and affordable--program.

Even the strongest proponents of expansive new drug coverage (including the American Association of Retired Persons, in testimony before the Energy and Commerce Subcommittee on Health and the Environment on May 21) acknowledge that little data exist on the potential use of new drug benefits under Medicare, the costs of such coverage and the administration of such a program.

The Congressional Budget Office and the Health Care Financing Administration are each preparing estimates for the cost of covering prescription drugs under Medicare. We understand that these estimates differ by a considerable margin. Actual data from the Pennsylvania pharmaceutical assistance program for the aged show that the average annual cost of medicines now exceeds $400 per enrollee. And based on the last quarter of 1986, we estimate that nearly 30 percent of the Pennsylvania enrollees spend more than $400 a year for medicines. The average cost of providing drugs to elderly Medicaid recipients, according to HCFA data, was $368 per person in 1985. Clearly, a new drug benefit under Medicare should not be enacted until reliable estimates can be made of how much such a benefit would cost.

PMA believes that once the group in need is identified and costs can be more accurately assessed, it should be easier to determine how an appropriate program should be designed. A well-designed program should have several important features. It should:

- Be targeted to aid the elderly who need assistance, so the added premiums or taxes required to cover costs can be minimized.

- Assure that patients receive quality care.

- Provide physicians and patients with the freedom to choose from the full range of approved drug products.

- Include a low-cost, non-burdensome administrative procedure.

- Encourage--and not stifle--the continued development of new and more effective medicines.

The danger we see in hasty adoption of a new entitlement program--without carefully defining the problem so an appropriate solution can be devised--is that the costs of the program, and of its administration, will quickly exceed the initial estimates. As this Subcommittee knows, under-estimation of costs has frequently occurred in federal and state health-care programs. Such under-estimation of the costs of a new drug benefit will lead inevitably to proposals for cost-containment measures that would restrict freedom of choice, diminish quality of care and discourage the investment needed for future drug breakthroughs, thus denying those in need the benefits intended for them. Indeed, several such undesirable features already appear in pending bills.

Before Congress provides any new entitlement program, therefore, PMA urges that you order a comprehensive study to develop and analyze the data necessary to determine the most appropriate way for the government to provide prescription-drug coverage for the elderly in an affordable manner. We note that on Friday the Senate Finance Committee voted to report S. 1127 with a requirement to study drug benefits.

In any such study, a number of factors should be considered:

- Determination of current levels of spending by the elderly for prescription drugs, as well as the number of older persons unable to afford adequate drug therapy, should be the top priority.

- The long-term fiscal viability of the Medicare program has always been a concern, and care must be taken not to jeopardize the financial condition of the program or to intensify such concern. Already, the premium for existing Medicare benefits will automatically be increased by law in October from $17.90 to $22.80 a month. Catastrophic coverage will require an additional premium. Further, in addition to catastrophic coverage, the main concern of the elderly is to obtain coverage for long-term health care, a very major additional cost. And there are other pressing medical needs, including the billions of dollars in unplanned expenditures that inevitably will be required in federal and state budgets to meet AIDS-related demands in the early 1990s.

- Nine states (New York, Pennsylvania, Illinois, Maine, Rhode Island, Connecticut, New Jersey, Delaware and Maryland) already have enacted Pharmaceutical Assistance for the Aged programs for low-income elderly persons who do not qualify for Medicaid benefits. These programs cover 1.3 million people. Six additional states (Massachusetts, Ohio, Michigan, Vermont, Florida and Alabama) are considering such programs. These efforts should be carefully studied, and consideration should be given as to how a federal assistance program should relate to existing state-administered Medicaid drug programs--under which 2 1/2 million elderly Americans received drug benefits in Fiscal Year 1985--and Pharmaceutical Assistance for the Aged systems.

- The manner in which a federal program would interrelate with other forms of drug coverage should also be considered. The American Association of Retired Persons testified on May 21 that more than 41 percent of the elderly population has some form of drug coverage. More than 50 percent of the enrollees in the Pennsylvania assistance program have other coverage.

- Special attention should be given to administrative procedures, in view of the fact that, because of the large number of transactions, administrative costs tend to be very high for drug programs. Secretary of Health and Human Services Otis R. Bowen, in testifying before the Subcommittee on Health and the Environment on May 27, said the administrative costs of a new drug program under Medicare would greatly exceed $500 million. In a 1986 report, the House Appropriations Committee pointed out that less than 8 percent of Medicaid benefits are for drugs--but that these benefits account for 50 percent of the paperwork. And the United Auto Workers noted in recent testimony that it would be very costly to administer a program of drug benefits with a high deductible.

- The incentives for continued investment in pharmaceutical research and development should be preserved, and not impaired. The best hope to treat disease--including those of special concern to the elderly such as heart disease, cancer and Alzheimer's disease--lies in the R&D efforts of the research-based pharmaceutical industry.

Turning to pending legislative proposals, PMA would like to make several points. First, estimated savings through the use of generic instead of pioneer products have been highly exaggerated. We understand that the CBO has assumed that generics are available at 50 percent of the prices of pioneer products. A 1986 study by the Federal Trade Commission found that generics average only 25 percent lower than the prices of pioneer products. And it is not even clear that this figure is accurate. Dr. Bernard S. Bloom of the University of Pennsylvania, in a study of almost 900,000 individual prescriptions published in the November 14, 1986 issue of the Journal of the American Medical Association, found that the price of generics was actually higher than the price of pioneer products in a number of cases, often was similar to the pioneer price and seldom was 50 percent or less than the price of the pioneer drug. Dr. Bloom concluded that shopping around among pharmacies frequently was far more important to saving money than simply specifying a generic product.

In addition, pending legislative proposals would establish restrictive drug formularies, which numerous studies have shown are counter-productive as cost-containment controls. These analyses indicate that restrictive formularies produce higher program costs by increasing expenditures in other areas such as hospitalization and surgery. For this reason, restrictive formulary initiatives were rejected in recent years in Louisiana, Oregon and Pennsylvania. In addition, South Carolina and Utah eliminated restrictive Medicaid formularies and adopted comprehensive drug coverage.

The experience of state Medicaid programs also shows that it can take considerable time--a year or two and sometimes three--for new medical therapy approved by the Food and Drug Administration to be added to formularies. This means that patients are denied access to important new medicines during the waiting period. And patients may never receive appropriate drug therapy that is never listed on a formulary.

Pending legislative proposals also refer confusingly to "therapeutic equivalents." We are not certain of the intent, but this could be taken to refer to "therapeutic substitution"--the dispensing by a pharmacist to a patient of a different chemical than the chemical prescribed by the patient's physician. This is not to be confused with generic substitution. This is drug switching. All 50 states prohibit such action--which could be detrimental to the patient's health--by retail pharmacies, and this prohibition should be preserved in the interest of public health.

In conclusion, PMA strongly believes that older Americans should receive the very best and most cost-effective medical care, including access to modern medicines. At this time, however, there are far more questions than answers about the best way to design a new drug-benefit program in support of this goal. Congress should authorize a comprehensive study, on an expedited basis, to develop the data necessary to design an appropriate and affordable program. PMA will continue its own review of the options, and would be pleased to cooperate fully with a Congressional study.

Mr. Chairman, that concludes my statement. I would be pleased to respond to any questions you or other members of the Subcommittee may have.

# MEDICAID COST CONTAINMENT

## Introduction

Medicaid is a joint federal-state program designed to provide health care to the poor. It has become one of the largest, most complex programs administered by the states, and now provides health care to approximately 22 million people. Total funding for Medicaid has increased dramatically over the last fifteen years -- from $2.2 billion in 1970 to $39.5 billion in 1985.

For individual states, Medicaid has for some time represented one of the largest state programs in terms of appropriations. Confronted by Federal budget constraints plus public opposition to increased state taxes, most states have undertaken major cost containment initiatives during the past few years. In many cases, the target of these state initiatives has been the Medicaid pharmacy program, which provides prescription drugs for Medicaid recipients.

The PMA fully understands the limited resources available to states but believes that proposals that reduce pharmaceutical benefits under Medicaid are particularly ill-advised, given the small percentage that pharmaceuticals represent of overall expenditures as well as the vital cost containment role played by appropriate drug therapy. During fiscal year 1985, for example, only six cents of every national Medicaid dollar was spent on prescription drugs. Moreover, this figure has remained fairly constant over the past several years, and actually represents a decline from about 8 cents in 1970.

## Problems With Restricting Drug Availability

In an attempt to reduce drug expenditures, state Medicaid programs have frequently proposed the exclusion of certain categories of drugs from reimbursement, or the establishment of a restrictive formulary listing only those medications covered under Medicaid. PMA maintains, however, that these approaches do not constitute effective mechanisms for controlling costs and could adversely affect patient care.

If patients are unable to obtain the drug therapy prescribed by their physicians because of such restrictions, the result can be unnecessary hospitalization or repeated visits to the physician due to a worsening of their health condition. Because of the tremendous cost differential between the price of an average prescription and the cost of one day in a hospital, it takes a relatively small percentage of such cases to more than negate any savings in the drug program expected through formulary restrictions. Therefore, the economic consequences of formulary restrictions can be increased expenditures for hospitalization and additional physician visits to deal with medical problems that might have been avoided if physicians had access to their preferred drug therapy.

The June 1980 edition of Forum published by the Health Care Financing Administration succinctly stated the problem:

> ... cutting back of optional services, such as prescription drugs, can affect the quality of care. If a patient cannot afford prescribed medication, the full treatment cannot be carried out. Ailments that can be treated easily in an early

state may be much more difficult and costly to cure later ...1/

The critical role of prescription drugs in maintaining a high-quality health care system has been widely recognized by state government officials. For example, the National Black Caucus of State Legislators, a group especially sensitive to the needs of the disadvantaged, included the following statement in its 1982 resolution on Medicaid Cost Containment:

- Preventive types of health care services should be encouraged and adequately funded. A realistic approach to cost containment is based on an understanding of the interdependence in the health care system and an appreciation for the effect some services can have on reducing expenditures for other services. Therefore, moderate expenditure increases in certain areas may yield significant decreases in outlays for expensive services such as hospitalization, as well as obviate the need for significant reductions in necessary services.
    - Prescription drugs serve as a cost-effective first-line therapy for physicians which, if severely restricted, can lead to a deterioration in patients' health condition and the need for higher-cost treatment modalities. Given the need to contain state expenditures for Medicaid, states can ill-afford to make significant cuts in the prescription drug program, which acts as an impediment to the utilization of high-cost services.2/

Numerous studies have documented the negative consequences of restrictive formularies as a Medicaid cost containment device. These analyses indicate that restrictive formularies are not effective in controlling costs, lead to higher expenditures in non-pharmacy program areas, and may deny patients appropriate medical treatment. Findings from a number of studies conducted to date on restrictive formularies are noted below.

- A 1982 study of the California restrictive formulary and prior authorization system utilized intensive surveys with physicians and on-site audits of hospital admissions to assess the fiscal impact of the drug restrictions on non-pharmacy services. The physician survey yielded specific information on cases where individuals required unnecessary hospitalization, additional physician visits and multiple prescriptions due to the restrictive formulary/prior authorization system. The authors concluded that "total annual costs to Medi-Cal associated with utilization of additional, unnecessary services, as described by program providers, were projected to be $78.5 million."3/
- In 1976 Louisiana eliminated a substantial number of drugs from coverage under its Medicaid program. A study of the implementation of this restrictive formulary indicated that although drug expenditures decreased by $4.1 million, total program expenditures rose by $15.1 million, representing a large increase in total expenditures. After examining the relationship between changes in disease diagnoses and the uses of the removed drugs, the author suggested that the restrictive drug formulary had an adverse impact on the health status of the Medicaid population and had increased the costs for non-prescription services.4/
- A comparison of Louisiana's experience with that of the Texas Medicaid drug program (an "open formulary" system)

during the same period indicated that the large increases in the utilization of non-pharmacy services found in Louisiana were not reflective of widespread trends. The Texas-Louisiana comparison provided further validation of the original study's finding that savings achieved through restrictions on drugs were outweighed by increases in the use and costs of more expensive alternative services.5/

- A comparative analysis of states with open or closed (restrictive) formularies conducted by Dr. Robert Hammel of the University of Wisconsin indicated that closed formulary states spent more on a per capita basis for total medical care expenditures than did states without restrictive formularies.6/

The overall conclusion that can be derived from the above studies is that restrictive formularies are not effective in reducing Medicaid costs and tend to produce greater utilization of (and increased expenditures for) more costly services. Though the methodologies and formularies under scrutiny in these studies differ, the critical point is that despite these differences, the analyses have resulted in the same general conclusion.

These findings are not surprising, given the existing literature on specific drugs that documents their individual cost-effectiveness. Results from a few of these studies are noted below:

- Use of a beta blocker drug to prevent second heart attacks could save an estimated $4,000 to $7,500 per patient a year.7/

- Net annual benefits of using a beta blocker were estimated to range from $746 million to $1 billion in treating glaucoma -- and to be as high as $237 million in treating angina.8/

- In a study conducted on the cost effectiveness of a drug used in the treatment of ulcers, it was demonstrated that Medicaid expenditures for all forms of health care were 25 percent lower for those patients who received this drug during an ulcer episode. Hospitalization and physician expenditures for duodenal ulcers were 64 percent lower for patients treated with this drug, and they were hospitalized 20 percent fewer days for all types of health problems.9/

- Another analysis, which looked at one state Medicaid program which deleted this drug from its restrictive formulary, yielded evidence that this action might produce for the long term a much higher incidence of expensive care.10/

- In the treatment of mental illness, one study demonstrated that drug therapy was lower in cost than other forms of treatment by 26.1 percent to 62 percent.11/

Besides the cost implications of restrictions on drug availability, there are of course profound social consequences. In California, physicians have cited the negative effects of Medi-Cal's restrictive formulary on the quality of care both in legislative hearings and in response to a random survey.12/ Moreover, a 1984 study of the impact of terminating all Medicaid services -- conducted by the UCLA Center for the Health Sciences

-- documented a number of instances where severe health problems resulted from individuals not receiving needed medications due to the elimination of their Medicaid drug benefits.13/

## Limitations of Prior Approval Mechanisms

Sometimes the argument is made that the pitfalls of a restrictive or closed formulary can be remedied by a prior approval system, which allows reimbursement for non-formulary drugs if the physician first gets approval from some state official. However, there are two major problems with this approach.

First, the administrative costs of a prior approval system are significant. In California, the cost of their Medicaid prior approval system for drugs was estimated to be $904,385 in 1982 -- equalling a processing cost of $8.21 per drug request. The California Budget Office in 1982 reported that 20 staff persons were responsible for processing drug prior approval requests.14/ These high costs were noted by a California judge in a lawsuit involving the state's Medicaid prior approval process. In one 18-day period, a regional office for prior approval spent $61,620 in administrative costs to turn down 1,999 requests for exceptions to the drug formulary restrictions -- causing the judge to comment that buying the drugs would have been cheaper.15/

Second, although they are proposed as a safety valve to compensate for the admitted weaknesses of a restrictive formulary, prior approval systems can easily become a major barrier to the timely delivery of appropriate drug therapy. In seeking prior approval to use a specific medication, physicians (1) may experience difficulties in making contact with persons responsible for prior approval; (2) may be faced with inordinate delays in obtaining approval; or (3) may in fact have their preferred treatment rejected by a state official who has limited information on the medical history of the patient. As a result, physicians may be discouraged from using the system and patients may not receive needed medications.

The overall adverse impact of such a system on quality of care and on health care costs was illustrated in a lawsuit filed in California in 1983. The Medi-Cal program refused to provide reimbursement for a medication costing $4.20 for a patient suffering from a congenital heart condition. The patient went without the medication, developed medical complications, and subsequently sought assistance in a hospital emergency room -- an episode which the patient claimed ultimately cost the state $684.16/ In sum, there are significant problems with Medicaid prior authorization systems which reduce their ability to resolve the pitfalls of restrictive formularies.

## More Prudent Alternatives

States should exhaust the ways in which services can be delivered effectively and more efficiently before adopting policies that in the long run may increase costs, such as excluding drugs from reimbursement. Among the various other cost containment options available to the states include: (1) programs to minimize patient and provider abuse, (2) drug utilization review, (3) cost-sharing for prescription drugs and other services to promote proper utilization, and (4) requiring more economical prescription sizes for certain medications. The first two options are briefly reviewed below.

Misuse of Medical Services. Unnecessary utilization of medical services has been a serious and costly problem within Medicaid.

utilization controls are or should be an important element of any management approach to Medicaid cost containment.

The Texas Medicaid drug program, for example, utilizes a claim screening procedure both before and after a Medicaid payment has been made. There are over 20 pre-payment screens, and numerous post-payment screens. Through the use of these screens, computer programs can generate profiles for providers and recipients who have been identified as possible program abusers. Then a team of field auditors do the required fiscal accountability checks to determine if in fact program abuse has occurred.

Although fraud and abuse efforts traditionally have been directed at provider groups, several states have launched programs designed to identify and correct abuses by beneficiaries through recipient restriction programs. These programs restrict the recipient to a single primary physician, a single pharmacy, and/or other category of provider.

The recipient restriction concept is a direct response to individual cases of chronic recipient misutilization of services, and serves both quality assurance and cost containment goals. The object is to concentrate management of the recipient's care in the hands of a single primary physician or other provider. Although the recipient can select the appropriate provider, this approach serves to improve the continuity and quality of care for the recipient as well as reduce Medicaid expenditures for unnecessary or inappropriate services.

The experience of Minnesota attests to the benefits of this type of program. The Minnesota Recipient Restriction Program improved utilization behavior without reducing the amount of services available to the restricted recipient. Average net savings per recipient ranged from about $4,400 to $5,000 over a 24-month period, a savings of $1.38 to $2.77 per dollar invested in the program. Equally as important, participants exhibited average reductions of 35 to 47 percent in rates of service utilization during restriction and exhibited significant continued reductions of both utilization and expenditures after the restriction was lifted.17/

Drug Utilization Review. Drug utilization review (DUR) seeks to improve drug therapy and to reduce Medicaid program expenditures through detection and correction of actual or potential drug therapy problems. Specific objectives of DUR programs are to prevent underutilization or overutilization of medications, to prevent drug induced effects and adverse reactions, and to prevent undesirable effects resulting from the combined use of two or more medications. These problems can result, for example, from the patient's receiving multiple prescriptions from more than one physician or not following the recommended drug regimen. DUR programs are designed to capture information about high-risk patients through the use of computer technology, and to inform the primary physician about the problems identified so that adjustments in drug therapy can be made.

Besides improving health care, effective DUR programs can reduce Medicaid expenditures by preventing unnecessary hospitalization caused by inappropriate drug use. Obviously, savings can also be achieved in other service areas by improving health care through better use of medications.

Several states have implemented DUR programs. In Virginia, an analysis of a DUR program implemented in 1985 indicated that 286 cases of hospitalization may have been avoided due to the program -- resulting in an estimated savings of $409,000.18/ Understandably, the analysis pointed out the obvious difficulty of isolating the specific effect of DUR from other intervening variables.

In Florida, the Inspector General of the Department of Health and Rehabilitative Services concluded that its DUR program had "potential as a cost and quality control mechanism," although the project did not produce major savings during its first year of operation.19/ In short, drug utilization review shows considerable promise as a cost savings program that does not require a cutback in needed services.

## Conclusion

In summary, numerous studies and state experiences indicate that prescription drugs play a cost-effective role in state Medicaid programs. They also suggest that efforts aimed at restricting the availability of drugs may well result in significantly increased costs for more expensive services, such a physician visits and hospitalization, and thus in greater total costs for the overall Medicaid program. There are better cost containment alternatives that state and federal policy makers should explore in order to contain costs in the Medicaid program.

PMA State Government Affairs
August, 1986

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## Medicare Drug Coverage for the Elderly
## Variations in Key Cost Elements

| | Expenditures per Enrollee $ | % of Enrollees Spending More than $400 |
|---|---|---|
| CBO | $200 * | 13.8 % * |
| HCFA | $300 (?)* | 19.5 % (?)* |
| Pennsylvania PACE Program | $400 ** | 30 % ** |
| New Jersey Pharmaceutical Assist. Prog. | $380 ** | ? |
| Medicaid | $368 ** | ? |

* Estimated

** Based on actual data

Mr. ANTHONY. I thank all of the witnesses. Until Mr. Stark is able to come back I have some general questions I would like to pursue with you.

I do not know how many of you may have been in the audience this morning at the beginning of the hearing, but my personal concern is not that there is a need, and not that the Congress should eventually act to do something about prescription drugs. Mine is a matter of timing.

I would just ask this question to the panel and just let each one of you go down in the order in which you testified and respond. Just tell me what your association's position would be on legislative strategy, and what harm would be done if we took all of the areas of concern, the areas of disagreement, and took more time to work our way through them, rather than trying to rush to a markup Thursday of this week.

Is there really any harm done? I guess is what I am asking. Or had you rather us just go ahead and move with what data we have available, knowing that there are conflicts and differences of opinion?

I am asking more for a strategy standpoint than I am in terms of what your philosophy is for or against a program, but I would like to hear each one of your association's be put on the record in terms of that.

Ms. BABINGTON. I will go ahead and speak first for the American Pharmaceutical Association. I think there are a couple of comments to make here.

No. 1, I think that most of the people who testified this morning did indicate that the data is out there and is available. They just did not necessarily have it with them, but they thought they could get it, but maybe not necessarily by Thursday.

We, too, feel that there is some information that has been collected in various States and that we could probably collect some from our members that would be helpful, and it would not take so long to do this, so that perhaps we should continue to move along with this and maybe make some adjustments as we go along. But I would not want to slow down the process too much waiting for huge drawnout studies to be conducted.

As far as what harm might be done by waiting, my personal feeling, and I think I would speak for most pharmacists who see this kind of patient, there are an awful lot of elderly people out there who have prescriptions but because they do not have the money—or for whatever reason, but primarily financial—they do not get them filled, or they do not fill them completely, or they will cut their dose in half themselves, or stop taking a drug arbitrarily because they do not have the money to continue the therapy.

These people end up in the emergency rooms and being admitted to the hospital to get restabilized for their diabetes or hypertension or whatever, and it all boils down to the fact that they did not take their medications properly.

Our feeling is that if we would go ahead and spend the money now to take care of these people on their medications, in the long run we would see a tremendous decrease in the overall Medicare cost because you are not going to see these people every month in the emergency room and spending two or three nights in the hospital every month just because they stopped taking their medication.

So, you can pay a little bit now to save a whole lot later on.

Mr. ANTHONY. How long has that problem existed?

Ms. BABINGTON. That problem has existed from the beginning of physicians writing prescriptions and patients going to the pharmacy.

Mr. ANTHONY. But it just did not show up in 1987?

Ms. BABINGTON. Oh, no. This has been going on for a long time. Studies back in the early 1980's showed that 4 percent of the hospital admissions were strictly due to people not taking their drugs correctly, and my guess would be that that percentage has risen a great deal in the last few years as drug therapy has become more complicated and more expensive.

Mr. RECTOR. In specific answer to your question, we would not want to do anything to slow down the process if, in fact, the train is leaving the station, so to speak. We would not want the——

Mr. ANTHONY. What if the wrong cargo gets on the train? Would it change your opinion then?

Mr. RECTOR. I would change our opinion. Some people have just joined the debate. I think that has confused the matter. Like the PMA, for example. They have been sitting on the sidelines thinking they could avoid the discussion. I think that has exacerbated things in the last couple of weeks.

There is no doubt that we need to hear from everybody, and everybody needs to come forth with information. I know we were here on April 23 and there was activity before that. There should be a concern about getting every "i" dotted and every "t" crossed, but at some point you are just going to run into substantive differences as to whether there should be a program or not, such as the discussion about formulary.

We would like to see a viable, bipartisan strong program enacted. If it takes another week or two more than what was on the agenda, I cannot see that it would do any harm.

Mr. ANTHONY. Thank you. Patrick?

Mr. DONOHO. I guess it boils down into a number of different areas. I would look at it first in the premium area and your cost area. I am not sure that waiting will provide—I think it will provide you a better handle on how much it will cost, but from what I understand from the draft outline, that is passed on in premium dollars.

I think the issue on premiums is also going to be exacerbated over time. If we look at the experience in the Medicaid programs, we have 10 to 15 percent increases annually in those, and you have seen about every conceivable, I guess, variation on that outline and formularies and everything else. But that increase is in there.

I would suggest that that is one of the reasons your questions directly relate to one of the reasons we suggested demonstration projects be initiated. Because it is our feeling that the dawn of electronics, the dawn of new things can give us an opportunity to better structure health care, particularly the pharmacy providers.

Our business is cash and carry right now, and you are asking me to put that into an accounts receivable. Eighty-three percent of 67 million prescriptions a year for my company are cash and carry.

The elderly walk in with a $10 bill and walk out with a prescription now.

But I am not saying that a studying and delaying action by Congress is going to improve anything, necessarily. I think some of the new technologies need to be tested, need to be looked at.

The other suggestion that I have seen work in the States is a sunset. The elderly program in the State of Pennsylvania right now is going through the sunset system, and if the legislature in Pennsylvania does not act, it will not exist next year.

Mr. ANTHONY. How long was the original provision?

Mr. DONOHO. I believe the original provision was three years. It has been in existence, I think, since 1984. That gives an opportunity for the legislature to step back, look at the program, and maybe redesign it. Because, one of the things that has been interesting in that program is that the costs have increased. Product costs have been tied to the copayment increases, and the past administration in Pennsylvania decided to ignore that statute.

What they are looking at now is they are going to have to go back and change that system in the sunset process, from my understanding.

Mr. ANTHONY. Okay. Robert, tell us how come you have been on the sideline.

Mr. ALLNUTT. Can I answer that second? As our statement says, we believe there is a need for a review of what programs are in effect, and that is probably going to show that through a combination of private efforts, Federal and State efforts, that there is need to cover the needy elderly who are not able to afford prescription drugs.

Our argument is that it is important to start that program off on the right foot and with a careful definition of what is involved and what is not involved, rather than to plunge into one and find out that there are mistakes that could have been rectified at the beginning, so we would urge that there be a study first.

We had the problem that I guess associations sometimes have, Mr. Anthony, of not wanting to sit on the sidelines, but on the other hand, not wanting to speak for a divided industry and wanting to form a position which we formed through our board of directors which did meet in May and took a position. And it is only now that we are able to be here and take this position.

Mr. ANTHONY. Would you expand just for a moment on your fear about the impact in research and development?

Mr. ALLNUTT. Well, the fear is as follows. If a program is launched based on very low estimates of what the cost would be and then it is quickly found out the costs are much higher, there would be a series of kinds of actions taken. And we have seen this happen in the States.

We see it now in the HCFA proposals under Medicaid that all of the associations at this table have considerable difficulty with, where formulas are invented, arbitrary rules set for reimbursement prices, formularies are created. The chairman's outline already has a formulary in it.

Each of those impacts, obviously, on a number of the players in the picture. Pharmacy ends up finding it does not get the $4.50 escalating every year. We find that some of our products are now listed on formularies, that when a new drug comes to the market available to most people it is not available to beneficiaries of the program. Therefore, return on investment is less. So that there is an automatic feedback into the motivation to continue to do research.

Mr. PICKLE. Has the gentleman from Arkansas finished?

Mr. ANTHONY. Mr. Pickle, I am not nearly finished, but I am going to yield to my senior member.

Mr. PICKLE. The House is in session and we have a vote. I will yield back to you in just a minute.

Let me ask you, as a group I understand you have all testified in written copies for prescription drugs. I also take it that none of you has specifically endorsed the Stark proposal, or any one proposal, that you are for the proposition, but each of you wants some kind of modification or change or correction in it; that is correct, is it not?

We have your copy and your testimony, and while I have not had a chance to read it all, it puts us in the position that you are for this but you want it done differently. We have 48 hours to try to consider your positions.

I also noticed that one or two of you did not favor assignment of the pharmacists—that is, mandatory assignment. Who testified to that? Do any of you favor mandatory assignment for pharmacists?

Mr. ALLNUTT. The manufacturers have no position one way or the other on that.

Mr. PICKLE. Do any of you? Someone testified in this copy that they had questions about the assignment position.

Mr. DONOHO. We accept assignment under Medicaid and we accept assignment on the other——

Mr. PICKLE. So this is not a problem for you?

Mr. DONOHO. No.

Ms. BABINGTON. I would say it is not a problem as long as we can have the system work such that there is, as I said before, not only adequate reimbursement as it starts out today, but in the long run we have got to keep it going and make sure it stays current so that we do not run into the problems we have had with the Medicaid program over the years where they just keep cutting us back and cutting us back until we eventually were suffering a loss on a lot of the prescription drugs that we fill on our Medicaid programs.

Mr. PICKLE. Who is the representative from NARD? You adopted your policy, then you say, "The source of our caution is predicated on the less than favorable experience that our members have had with"—I think you stated, "mandatory drugs, mandatory assignment?"

Mr. RECTOR. That may refer to mandatory co-pay. We do not have any difficulty with assignment.

Mr. PICKLE. You say, "Patients participating in these programs also must be ensured that they will have the right to select the pharmacist and pharmacy of their choice."

You just say you want them to have the right. But it just says the patient ought to have the right, and not the pharmacist.

Mr. RECTOR. Right. That the basic freedom of choice for the recipient remain in the statute as is presently the case.

Mr. Allnutt. Mr. Pickle, could I comment on the line that you are developing here? I think if you would put together all the provisions of the chairman's draft and the positions of the three pharmacy organizations here and you made those changes they recommended, you would find nothing very much resembling the chairman's draft, and that is part of the reason I think it becomes very difficult to have any idea of what the program is going to cost.

If you start making these kinds of changes, and others that other witnesses today have talked about, I do not think anyone really knows what we end up talking about, and that is why our position is that before that is done, before you come in Thursday and say, we will change this, change that, change the other thing, that you have a study of just what you ought to do and what it would cost.

Mr. Anthony. Mr. Pickle, if you would yield before these witnesses eat this microphone up, I think they may have a disagreement.

Mr. Rector. I think I can answer fairly succinctly Mr. Pickle's question. We, in fact, endorse the Stark proposal. We endorse the Waxman proposal. There are several differences that we spoke to them about earlier today.

We support the 20-percent coinsurance. There is a little wrinkle there about single source drugs. We suggest that if there is a continuing controversy about the formulary, that the formulary be authorized by statute to an out-year, depending on criteria, to determine whether it need be. There was a formulary in the 1971-72 Senate.

It is not that there is no history on this kind of provision. We support the bill. When it comes to words like "rural" we do not know whether you prefer standard metropolitan statistical area or the 65-mile-an-hour speed limit definition that you just enacted.

We endorse the bill, as we did the Waxman bill, with some of the fine tuning that was mentioned in our statement.

Mr. Pickle. Well, I think I understand your approach. We do not know the answers, and I do not know anyone who does at this point, but we have got to make some decision.

Did the gentleman from Arkansas have another question?

Mr. Anthony. Yes, very quickly, Mr. Chairman.

Last year the pharmacists in Arkansas contacted the entire Arkansas delegation complaining that HCFA with one letter overnight had changed their pricing mechanisms, or actually, the manner in which they calculated how they would reimburse pharmacists.

Pharmacists did not like it. And after they educated the members of the delegation on it, we did not like it. So we went to bat for our constituents. HCFA basically told us to go to blazes, that they liked it and they thought it was a good cost containment method, and basically the pharmacists were being unfair to our senior citizens.

So what I see you saying is that you are going to support this bill. And we are going to pass this bill because, obviously, the chairman thinks he has the votes. But I tell you, in 1988 you are going to write us a letter, because HCFA is going to do the same thing to you in Medicare, only this time I am not going to ask

HCFA to tell you to go to blazes, I am going to tell you to. [Laughter.]

Because I am going to go back to this hearing and I am going to point out where you totally supported it. So I am telling you your testimony is going to come back to haunt you. It disturbs me that everybody says the data is out there but nobody really lays the data out anyplace, and maybe that is the way it ought to be.

That is the privilege of the Chair's closing the meeting without a rebuttal. But I will give you a chance to rebut, and I am going to ask unanimous consent to strike that naughty word from the record, and hearing no objection it will be struck. [Laughter.]

If my mother heard that or read that, she would really get down on me.

But this situation is a real problem, it is a real concern of mine, because it was a glitch in the system that was made known to me by the pharmacists and we tried to respond, and the bureaucracy did not respond very well. As a result, it was not a very satisfactory conclusion to the problem.

So tell me what we could offer as an amendment in this bill Thursday so that we could stop that kind of procedure from happening, so that you will have a right of appeal, so that you will have a right of review, so that the pharmacists who are going to have to fill these prescriptions and get paid on a mandatory assignment basis will make sure that they do not have to subsidize the system, as you indicated. I think that this would be fair and I want to work with you on it.

I would love to stay here and hear your rebuttal, but I am also going to go make that vote.

I will tell you what. We will do something real unusual. If Mr. Stark comes back in the next 10 minutes, we are in recess. If he does not show up, we are adjourned.

[In response, Mr. Rector submitted the following:]

One of the reasons we support the Stark/Waxman Medicare Outpatient Drug bills is that, unlike the non-statutory Medicaid prescription drug program, totally subjected to the whims of HCFA employees, these bills provide the terms of Medicare reimbursement in the statute.

Incidentally, our testimony of 4-23 as well as 6-2 reiterate, in our view, the need to similarly establish a statutory basis for the Medicaid prescription drug program. It is this lack of statutory basis that has permitted HCFA to conduct anti-small business campaigns such as the 85/86 effort to confiscate earned discounts.

If the terms of reimbursement had been in the Medicaid statutes, as they are in the Stark/Waxman bills, we and the pharmacists of Arkansas would have been discussing, if anything, with Mr. Anthony, matters other than the unregulated, unguided conduct of HCFA bureaucrats.

Regarding the future areas of agreeing and disagreeing, hopefully more of the former, we defer to Mr. Anthony as to whom should be directed to the place so well described by Dante.

[Whereupon, at 2:50 p.m., the hearing was adjourned.]

[Submission for the record follows:]

# STATEMENT OF THE
# HEALTH INSURANCE ASSOCIATION OF AMERICA

The HIAA is a trade association of about 335 insurance companies who write approximately 85% of the private health insurance written by health insurance companies in the United States.

We would like to address some of the administrative aspects of a bill to provide coverage of catastrophic expenses for prescription drugs and insulin under the Medicare program. Many HIAA member companies have considerable experience in providing prescription drug coverage to a broad spectrum of the population.

If there is a single message to impart to the committee, it is the importance of keeping the administration of any drug plan as simple as possible. No other sector of health benefits administration produces a greater volume of claims. Each prescription equals a claim and in comparison to other health care claims, each drug claim represents a small dollar amount. If the process is too complex...valuable benefit dollars will be consumed in high administration costs.

There are two basic methods in reimbursing out patient prescription drugs. The first is a major medical or comprehensive plan where there is a set annual dollar deductible. After this threshold is reached, there is usually an 80/20 reimbursement, i.e., the beneficiary pays 20% and the plan picks up the balance. The second method is administering prescription drugs as a separate product line with a per prescription deductible. The beneficiary can obtain benefits from a network of participating pharmacies, including retail druggists and mail order companies. The pharmacist is usually reimbursed for the cost of the drug as defined by the plan, plus a professional fee after the per prescription deductible is satisfied. Most of the paperwork goes through clearing houses for ease of administrative handling.

We strongly recommend that the prescription drug plan you are considering follow the second approach.

Regarding the proposed legislation, we would like to make these observations:

- To ease administration of the $500 deductible, we think the Part B carriers will need a special claim form for prescription drugs. Futhermore, once the beneficiary has satisfied the deductible, pharmacist should be notified via the on-line claim adjudication system.
- In addition to a an annual deductible, we would recommend a per prescription cost sharing arrangement, i.e., either a per prescription deductible or a percentage co-pay. We feel that this will control the overall cost of the program, as well as hedge against over utilization.
- In the definition of the ingredient cost, we find reliance on the Average Wholesale Price (AWP) troublesome. Experience shows that in recent years AWP is a highly inflated number and most drugs are purchased at lesser amounts, at times substantially lower.
- The HIAA is pleased to see incentives in this bill to encourage the use of generic drugs where appropriate. The HIAA supports the use of generic drugs as an important cost containment vehicle to control health care expenditures providing the prescribed drugs are therapeutically equivalent and less expensive than its brand name counterparts. The HIAA does not support legislation

that could restrict the prescriber's right to designate a brand name or generic drug. We understand this bill includes specific provisions allowing physicians to specify brand named drugs.

- Any plan put into effect should be exempt from state restrictions placed on items in interstate commerce. For example, if mail order pharmacies are participating in such a plan, there should be no barrier to sending prescriptions across state lines.

- We hope your bill will allow for an appropriate amount of lead time in order to put the necessary administrative procedures in place. This act will create a huge volume of paper. At this time, a January, 1989 effective date seems reasonable.

- It also seems important to us that only federal legend drugs plus insulin be considered for purposes of meeting the deductible. Many prescribed items are not legend drugs.

- The bill's definition of "pharmacy" should be limited to bonafide licensed pharmacies.

- We think the bill should address limits on the supply of drugs which can be dispensed. There should be an upper limit, e.g., 90 day supply per prescription. Most drugs dispensed for this beneficiary group will be for chronic conditions, a long term needs.

- The increased administrative costs of Medicare's carriers must also be considered by the Congress in its annual appropriation for Medicare administration.

- On-line adjudication of claims at the pharmacy is being developed. This would flow naturally for this type of benefit.

- The bill mentions indexing. It is important that the indexing formula be simple, but realistic so as not to be a bonanza to any party.

- Administrative methods for overiding the formulary shuld be only developed after a careful cost-benefit analysis.

- Non-assigned claims for which direct reimbursement is requested should be subject to a test for "reasonableness."

We feel it is worthy to mention that prescription drug coverage for Medicare eligibles is available from the private sector under "medigap" plans. Benefits have been established by several states and cost effective drugs are sold by the pharmacies of the American Association of Retired Persons (AARP). In addition, greater use of generics, coupled with the ability to advertise drugs has somewhat alleviated upward pressure of drug costs in the retail sector.

The HIAA would be glad to provide further input into the review process of this bill.

In conclusion, if there is any point which should be stressed, it is that simplicity of administration benefits the beneficiary, the administrator and the government. Thank you for your attention.

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